## Title

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## Journal

Infection control and hospital epidemiology, 40(4)

## ISSN

0899-823X

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## Publication Date

2019-04-01

## DOI

10.1017/ice.2019.16

Peer reviewed

# Evaluation of Uncomplicated Acute Respiratory Tract Infections (ARI) Management in Veterans: A National Utilization Review

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**Keywords:** respiratory tract infections, practice patterns physicians, antimicrobials, drug utilization, primary care

**Running Title:** Management of Uncomplicated ARI

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**Short Summary:** In uncomplicated acute respiratory infections, we assessed congruence between clinical decision-making (diagnostic and treatment) and guideline recommendations. Antibiotics were prescribed in most visits, indicating substantial antibiotic overuse. Practice patterns were frequently incongruent with guideline diagnosis and treatment recommendations.

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**Abstract**:

**Background:** Antibiotics are overprescribed for acute respiratory tract infections (ARIs). Guidelines provide criteria to determine which patients should receive antibiotics. Limited data characterize congruence between practice and guideline recommendations and clinical outcomes.

**Methods:** We assessed congruence between documentation of diagnostic and treatment practices with guideline recommendations for: pharyngitis, rhinosinusitis, bronchitis, and upper respiratory tract infections (URI-NOS). Visits in 28 Veterans Affairs facilities during the 2015-16 Winter season were reviewed. Manual records review identified complicated cases which were excluded. Data were extracted for visits meeting criteria, followed by analysis of practice patterns, guideline congruence, and outcomes.

**Results:** 4,305 of 5,740 visits met criteria: pharyngitis (n=558), rhinosinusitis (n=715), bronchitis (n=1,155), URI-NOS (n=1,475), or mixed diagnoses (>1 simultaneous ARI diagnosis) (n=402). Antibiotics were prescribed in 68% of visits: pharyngitis (69%), rhinosinusitis (89%), bronchitis (86%), URI-NOS (37%), and mixed diagnosis (86%). Streptococcal diagnostic testing was performed in 33% of pharyngitis visits; Group A *Streptococcus* was identified in 3% of visits. Streptococcal tests were ordered less frequently in patients who received antibiotics 28% than those who did not receive antibiotics 44% ($P<0.01$). While 68% of visits for rhinosinusitis had documentation of symptoms; only 32% met diagnostic criteria for antibiotics. Overall, 39% of patients with uncomplicated ARIs received appropriate antibiotic management. The proportion of 30-day return visits for ARI care was similar for appropriate (11%) or inappropriate (10%) antibiotic management ($P= 0.22$).

**Conclusions:** Antibiotics were prescribed in most uncomplicated ARI visits indicating substantial antibiotic overuse. Practice were frequently discordant with guideline diagnosis and treatment recommendations.

## Introduction

Acute respiratory tract infections (ARIs), including rhinosinusitis, pharyngitis, bronchitis, and common cold (URI-NOS), account for 30% of antibiotics prescribed in outpatient settings, yet viruses cause most ARIs.[1] Antibiotics are indicated for rhinosinusitis and pharyngitis if specific criteria are met.[1,2] Infectious Diseases Society of America (IDSA) guidelines for management of Streptococcal pharyngitis recommend identifying suitable candidates for Group A *Streptococcus* testing and prescribing antibiotics only for patients with positive results.[3] IDSA guidelines recommend antibiotic treatment for bacterial rhinosinusitis based on identifying constellations of signs and symptoms to determine probability of bacterial infection: prolonged symptom duration, worsening after initial improvement, or severe presentation.[4,5] When antibiotics are indicated, guidelines recommend penicillin or penicillin derivatives except for patients with β-lactam allergy. Numerous sources recommend against routine antibiotic prescribing for acute bronchitis (unless pertussis is suspected) or URI-NOS. [2,6-7]

The Veterans Healthcare Administration (VHA) provides care to 7 million veterans nationwide through >150 VA Medical Centers (VAMC). In 2014, the VHA required each VAMC to implement an Antimicrobial Stewardship Program (ASP). Many VAMCs have developed robust inpatient ASPs.[8] However, most antibiotics are prescribed in the outpatient setting.[9] Antibiotic prescription for uncomplicated ARIs increased within the VHA between 2005 and 2012, and azithromycin was the leading antibiotic prescribed.[10]

The VA Center for Medication Safety (VAMedSAFE) is tasked with evaluating and promoting safe and effective drug therapy within the VHA through performance of medication utilization evaluations (MUE)s. An MUE is a systematic, criteria-based quality improvement analysis of medication or disease(s) designed to improve patient outcomes.[11] VAMedSAFE previously partnered with the VA Antimicrobial Stewardship Task Force to conduct MUEs to monitor and improve antibiotic therapy for pneumonia and urinary tract infections.[8,12,13]

The purpose of this MUE was to evaluate ARI diagnostic and treatment appropriateness, and to inform the development of a VHA-wide Campaign to improve ARI management. Objectives were: 1) determine the frequency of appropriate antibiotic management (i.e., appropriately withholding or

initiating antibiotic therapy based on documentation of clinical and diagnostic criteria) congruent with published guidelines, and 2) comparison of relevant outcomes between those who did or did not receive appropriate antibiotic management.

**Methods**

VAMedSAFE created a retrospective cohort of patient-visits from Veterans with an outpatient ARI diagnosis for 28 VAMCs that volunteered to participate in the MUE. The first eligible visit for each patient during the evaluation time-period was included. Diagnoses were identified by International Classification of Diseases 10th Clinical Modification (ICD-10 CM) codes for acute rhinosinusitis, pharyngitis, bronchitis, or URI-NOS for visits occurring between October 1, 2015 and March 30, 2016.[14] **(Appendix A)** Visits were excluded for: complete lack of ARI symptom or treatment documentation, resolved ARI on visit date, hospitalization within 1 day after visit, antecedent ARI within 30 days, chronic sinusitis or pharyngitis, concurrent non-ARI infection requiring antibiotics, antibiotic self-treatment or chronic antibiotic use. Further, patients with select comorbidities were excluded: chronic lung disease (COPD), end stage renal disease, active neoplasm, marrow or organ transplantation, HIV, and other immunocompromising conditions. **(Appendix A)** A prescription for an oral antibiotic dispensed from the VHA <2 days before or <3 days after the encounter was attributed to the visit.[10]

Potential cases were extracted from electronic data using inclusion criteria by VAMedSAFE from the VHA Corporate Data Warehouse (CDW) in collaboration with the Informatics Decision Enhancement and Analytic Sciences Center (IDEAS 2.0).[15] Exclusions based on ICD-10 codes and prescription data, select patient demographics, co-morbidities, and 30-day all-cause hospitalization were extracted as well. Local reviewers, blinded to specific ARI diagnoses, were provided lists of ≤250 visits per facility. These reviewers (antibiotic stewards and trainees) performed manual review of electronic health records to confirm and/or extract inclusion and exclusion criteria, signs and symptoms, provider indicated diagnoses, laboratory test results, antibiotics(s) prescribed, and outcomes. A data abstraction protocol, case report form, and monthly teleconferences facilitated standardized data collection. **(See**

**supplementary Appendix B)** Completed cases were uploaded to a VAMedSAFE database for integration and analysis.

Indications for antibiotic initiation and definitions of appropriate therapy were adapted from guideline recommendations.[2-7] For pharyngitis, penicillin or amoxicillin were appropriate first-line therapies for patients with a positive rapid antigen detection test (RADT) or a throat culture positive for Group A, C, or G *Streptococcus*.[3] First generation cephalosporins, clindamycin, or macrolides were appropriate second-line therapies for patients with penicillin allergy. For rhinosinusitis, amoxicillin/clavulanate or amoxicillin were considered appropriate first-line therapies in patients with purulent nasal discharge and/or facial pain/pressure/fullness plus one of the following: prolonged (≥7days), severe (temperature ≥102 F for >2 days), or worsening symptoms after ≥4 days.[4-5] Tetracyclines, moxifloxacin, or levofloxacin were appropriate second-line therapies for patients with penicillin allergy. For acute bronchitis, azithromycin or trimethoprim/sulfamethoxazole therapy (in case of macrolide allergy) was considered appropriate if the provider documented suspicion of pertussis exposure or performed pertussis testing.[6,7] For URI-NOS, antibiotic therapy was considered inappropriate.[2] Based upon ARI diagnosis, documentation of diagnostic criteria, antibiotic initiation, and antibiotic selection, antibiotic management for each case was classified as appropriate or inappropriate. Visits with mixed ARIs (>1 simultaneous ARI diagnosis) or those with a "delayed prescriptions" filled outside of the 3-day post-visit window were excluded from the appropriate management and outcomes assessments.

Demographics, signs, symptoms, diagnostics, antibiotics prescribed, and outcomes were compared with descriptive statistics, parametric or non-parametric tests as indicated (two-tailed P value <0.05 defined significance). **(SAS$^{R}$, v 9.4, SAS Institute, Cary NC)** Outcomes were reported based upon appropriate and inappropriate antibiotic management classifications.

Based on VA Policy Handbook 1058.05, which defines operations activities that constitute research, this evaluation was deemed to be quality improvement and exempt from VA Human Subjects

Research requirements by the Hines VA Institutional Review Board.[16] Data Use Agreements were signed by all participating sites.

**Results**

Of visits reviewed, 4,305/5,740, [75%] met criteria for assessment of diagnosis, and 3,884/5,740, [68%] met criteria for assessment of antibiotic management appropriateness and outcomes. **(Figure I)** Most patients were male and middle-aged with limited co-morbidity. **(Table I)** Few patients exhibited abnormal vital signs. Overall, 2,897/4,285, [68%] of patients with uncomplicated ARIs received antibiotics. Recipients were more likely male, smokers, and seen in the Emergency Department compared to antibiotic non-recipients. Mid-level providers prescribed antibiotics more often than staff physicians, and medical trainees prescribed antibiotics less often than staff physicians or mid-level providers.

Most patients (567/715, [79%]) diagnosed with rhinosinusitis had documentation of purulent nasal discharge and/or facial pain, pressure, or fullness upon presentation. **(Table II)** Of those patients (216/567, [38%]) had documentation of additional criteria for antibiotic therapy, predominantly prolonged symptoms (≥7 days). Antibiotics were prescribed in 633/709, [89%] of rhinosinusitis visits eligible for evaluation, of which 203/633 [32%] met complete diagnostic criteria for antibiotic therapy. When antibiotics were prescribed, 389/633 [61%] patients received first-line and 66/633 [10%] received second-line antibiotics. The rest (178/633, [28%]) received non-recommended antibiotics. Based on chart documentation of rhinosinusitis symptoms, antibiotic selection, and appropriately withheld antibiotics, 226/709 [32%] received appropriate antibiotic management.

Most patients (432/558, [77%]) with a pharyngitis diagnosis lacked Centor score component documentation or had Centor scores of <2, indicating few patients met streptococcal testing recommendations.[17] **(Table II)** β-hemolytic *Streptococcus* testing was performed in 185/558 [33%] of visits, and was more likely to be performed in patients with ≥2 Centor criteria (53/126, [42%]) than those with <2 criteria (132/432, [31%], P=<0.02). Overall, 17/558 [3%] of patients diagnosed with pharyngitis had testing positive for Group A *Streptococcus*. Antibiotic therapy was prescribed to 384/556 [69%]

patients with pharyngitis eligible for evaluation; of these, 102/384 [27%] had ≥2 Centor criteria documented, indicating likelihood of Streptococcal pharyngitis high enough to warrant testing. Of patients with pharyngitis prescribed antibiotics, 147/384 [38%] received first-line therapy, 123/384 [32%] received second-line therapy, while 34/384 [9%] of patients that received antibiotics had a documented penicillin allergy. Streptococcal tests were ordered less frequently in patients who received antibiotics (108/185 [28%]) than those who did not receive antibiotics (77/185 [44%], p<0.01). Based on evidence of β-hemolytic streptococcal infection, antibiotic selection, and appropriately withheld antibiotics, 194/556 [35%] received appropriate antibiotic management of pharyngitis.

Of patients with an acute bronchitis diagnosis, 7/1,154 [<1%] had documentation of concern for pertussis exposure, confirmed exposure or infection. These patients underwent diagnostic testing, but none tested positive for pertussis. Antibiotics were prescribed in 990/1,148 [86%] of acute bronchitis visits eligible for evaluation, of which azithromycin was prescribed to 614/990 [62%]**.** Based on chart documentation of pertussis concerns and appropriately withheld antibiotics, 159/1,148 [14%] received appropriate antibiotic management for acute bronchitis. For patients diagnosed with URI-NOS, antibiotics, primarily azithromycin, 330/550 [60%], were prescribed to 550/1,471 [37%] of patients eligible for evaluation. Based on the proportion of patients who received antibiotics, 924/1,471 [63%] of patients diagnosed with URI-NOS received appropriate antibiotic management. In total 1,497/3,884/ [39%] of patients diagnosed with uncomplicated ARIs received appropriate antibiotic management.

After removal of visits with mixed diagnoses and delayed prescriptions, there were 704/3,884 [18%] follow-up encounters (in person or by phone) related to the initial ARI visit. Patient outcomes were assessed among two axes, patients who did or did not initially receive antibiotics **(Table III)** and patients who did or did not receive appropriate antibiotic management **(Table IV).** Among patients who did (457/2,552, [18%]) or did not (247/1,332, [19%]) initially receive antibiotics there was no difference in the frequency of additional encounters (P=0.65). However, patients with rhinosinusitis who did not receive antibiotics (22/79, [28%]) more commonly had a subsequent ARI-related encounter than patients who did receive antibiotics (106/630, [17%], P = 0.02). Patients who did not receive antibiotics in the

initial encounter were more likely to receive an antibiotic during a subsequent encounter (84/1,332 [6%] versus 105/2,552 [4%], P<0.01), especially for patients with an initial diagnosis of acute bronchitis (12/158, [8%] versus 39/990, [4%], P =0.04) or URI-NOS (58/921, [6%] versus 19/550, [4%], P = 0.02). Thirty-day *Clostridium difficile* infection (2/3,884, [<1%]) and 30-day hospitalization (33/3,884, [1%]) were uncommon and did not differ based on receipt of an antibiotic during the initial ARI visit.

Appropriate and inappropriate antibiotic management assessment revealed few differences in patient outcomes **(Table IV).** ARI-related return encounters were similar for patients who received appropriate (288/1,497, [19%]) versus inappropriate initial antibiotic management (416/2,387, [17%], P=0.15). However, patients who received initial appropriate management were more likely to receive an antibiotic during a return encounter (93/1,497, [6%]) than those who received inappropriate initial management (96/2,387, [4%], P<0.01). Patients who had antibiotics appropriately withheld were less likely to have a return encounter or patient initiated phone call than patients with antibiotics inappropriately withheld (239/1,314 [18%] vs. 8/18 [44%], P<0.01) and (35/1,314 [3%] vs. 2/18 [11%], P=0.03), respectively. Conversely, patients who had antibiotics appropriately initiated were more likely to have a return encounter or to initiate a follow-up phone call than patients who had antibiotics inappropriately initiated (54/230 [24%] vs. 403/2,322 [17%], P=0.02) and (12/230 [5%] vs. 69/2,322 [3%], P= 0.06). No difference in outcomes based on appropriate or inappropriate antibiotic selection was observed. Finally, no difference in rates of *C. difficile* infection or hospitalization between antibiotic recipients and non-recipients, or differences related to the appropriateness of antibiotic management, was observed.

**Discussion**

This cross-sectional MUE generated several noteworthy observations. First, an excessive proportion of patients with uncomplicated ARIs were treated with antibiotics. Antibiotics were given to two-thirds of patients, whereas we found full justification for antibiotic therapy in approximately 10% of visits. Second, chart-level review of rhinosinusitis and pharyngitis diagnostic documentation identified

limited congruence with guideline recommended criteria for antibiotic treatment. While 89% of patients diagnosed with rhinosinusitis received antibiotics, less than one-third documented diagnostic criteria for treatment, suggesting that many patients may have received unnecessary antibiotics. Third, less than a quarter of pharyngitis cases had documentation of ≥2 Centor criteria, the recommended threshold for performing Streptococcal diagnostic testing. Testing was performed in one-third of cases and providers were more likely to test patients meeting the recommended testing threshold. Antibiotics were prescribed less frequently in patients who underwent testing for β-Hemolytic Streptococcus than those not tested, suggesting that improvements in testing could lower antibiotic prescribing. While antibiotics were prescribed in two-thirds of patients with pharyngitis, only 5% of patients tested positive for β-hemolytic Streptococcus. Of patients treated, less than one-third received penicillin or amoxicillin. Third, documentation of suspected pertussis exposure and testing was rare and the proportion of acute bronchitis cases treated with antibiotics was high. Only seven documented cases of suspected exposure to pertussis occurred with no confirmed cases. Nonetheless, 86% of patients with acute bronchitis received antibiotics. Similarly, more than one-third of patients with URI-NOS, a condition where antibiotics are never indicated, were treated with antibiotics. Fourth, detailed assessments of patient outcomes relative to initial receipt of antibiotics indicated similar proportions of ARI-related return visits and low frequency of complications, *Clostridium difficile* infections, and hospitalizations. Patients that did not receive antibiotics during their initial encounter were more likely to receive them during a subsequent encounter; however, the overall frequency of subsequent visits with antibiotics prescribed was low. While there were few differences in outcomes for patients who received or did not receive appropriate antibiotic management, patients who had antibiotics inappropriately withheld were more likely to seek follow-up care. Finally, patients that had antibiotics appropriately initiated were more likely to receive follow-up care than patients with antibiotics inappropriately initiated. We were unable to ascertain the reason for this as there were no differences in worsening symptoms or infectious complications between groups.

A strength of this analysis includes the systematic removal of complicated ARI cases through extraction from the CDW, which was confirmed by manual chart review. The manual chart review

identified small numbers (278/5,740, [5%]) of additional patients with significant pulmonary and immunological co-morbidity **(Figure I)**, conditions where antibiotic use might be justified, verifying that the combination of diagnostic coding and recent prescription of select medications **(See supplementary Appendix A)** applied to electronic records was effective at identifying patients with comorbidity. While not all exclusions were identified by the algorithm, manual records review identified remaining cases not meeting uncomplicated ARI criteria. The manual records review also facilitated collection of information on documentation of clinical diagnostic criteria and verification of outcomes. These data, which were not retrievable through CDW databases, were used to conduct a detailed assessment of appropriate antibiotic management and clinical endpoints.

The analysis has several limitations. The VHA population is predominantly male, and not all Veterans receive care exclusively through the VHA. Some excluded cases identified through manual chart review indicated recent prior encounters that occurred outside the VHA, and it is possible that not all co-morbidities were documented within the VHA record, which could have impacted the accuracy of appropriate antibiotic management estimates. Further, the analysis excluded clinics without VHA pharmacy services for dispensing acute medications (i.e. Community-Based Outreach Clinics). Point-of-care rapid diagnostic testing availability within the VHA may be less than in private settings. A 2015 VA-wide survey of antimicrobial stewardship resources indicated that approximately half of VAMCs had RADT testing while throat culture testing was more widely available.[18] As this was a quality improvement evaluation with a consensus-based approach to MUE protocol development, the diagnostic and treatment criteria for rhinosinusitis were not identical to IDSA recommendations. For example, $\geq$ 7 days instead of 10 days was used to define the prolonged symptoms diagnostic threshold for treatment of rhinosinusitis, and amoxicillin in addition to amoxicillin clavulanate was considered acceptable first line therapy.[4-5] Since sites volunteered to participate, we cannot rule out bias in the characteristics of participating sites. Findings should not be generalized beyond uncomplicated ARI cases, as not all ARI visits identified by diagnostic codes met this definition.

Our findings parallel a VHA-wide analysis that reported an antibiotic prescribing rate of 69% in 2012.[10] Respiratory tract infections, primarily ARIs, account for 45% of all outpatient prescriptions with an overall estimated annual appropriate antibiotic prescribing rate ranging 45 to 63% for adults.[1] Our findings of 39% for appropriate antibiotic management based on manual records review are slightly lower than that claims-based estimate. Reports from nation-wide commercially insured populations suggest overall outpatient antibiotic use decreased 9% between 2010 and 2016 with a 16% reduction in pediatrics but only a 5% reduction in adults.[19] We recently reported a similar drop in outpatient antibiotic prescription for uncomplicated ARIs within the VHA system within a similar timeframe. [20] We found limited data on provider documentation of diagnostic criteria and their relationship to antibiotic treatment decisions for uncomplicated ARIs.[21-24] Similarly, a recent observational cohort study identified an 83% prescription rate for rhinosinusitis in adults and that 38% had symptoms for less than 3 days.[19] That study found a lower (48%) antibiotic prescribing rate for pharyngitis and a higher rate of RADT testing for pharyngitis (91%). Antibiotics were prescribed in 47% of patients who had negative RADTs or no RADT test done. Our analysis identified that patients who did not initially receive antibiotics were slightly more likely to subsequently receive one on a follow-up visit; which has been previously reported.[25] Finally, similar rates of return visits and low rates of complications for patients with ARIs irrespective of antibiotic treatment have been reported.[26,27]

While many approaches have been utilized to improve ARI management, few have demonstrated sustainability. [28] Our evaluation informed the development of a National VHA ARI Campaign to reduce unnecessary antibiotic use. Campaign components include provider-directed interventions of academic detailing coupled with audit/feedback. Preliminary results suggest improvements in appropriate antibiotic management for uncomplicated ARIs, although longitudinal follow-up is needed.[20] As scalability requires the ability to accurately identify, track, and report cases efficiently, further work is needed to assess diagnostic and treatment decisions without the need for chart review. Improvements in electronic medical record templates to capture ARI symptoms and Natural Language Processing may aid in that approach.[29-31] Finally, future work should include tools to capture and aid assessment of untoward patient outcomes

including antibiotic adverse events, rare infectious complications, and ecological effects such as antibiotic resistance associated with inappropriate management decisions.

Overall, we observed high rates of antibiotic prescription for uncomplicated ARIs in VHA outpatient settings, suggesting considerable overuse did not change substantially between 2012 and 2016. Practice patterns were frequently discordant with guideline diagnosis and treatment recommendations. Most patient-related outcomes were similar irrespective of treatment approach suggesting that interventions to reduce use inappropriate antibiotic management are needed.

**Acknowledgments**

The views expressed in this manuscript are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs. The authors acknowledge Kenneth Burkowski for assisting with the development of the data collection tools and data management as well as collaborators from the ARI Management Improvement Group. Collaborators are listed by VA membership at the time of MUE participation and some collaborators may no longer be practicing at affiliated locations.

Hudson Valley VAMC: Rita Bodine, Pharm D, Catherine Knapp PharmD; Bronx VA: Michael Gelman, MD, PhD, Kirsten Vest, PharmD, BCPS, Mei Chang, PharmD, BCPS-ID, BCCCP; Anchorage VA: Matthew Kirkland, PharmD; James Haley VAMC: Patrick Tu, PharmD, Amanda Mercurio, PharmD, BCPS, Sullivan Lynch, PharmD; Salem VAMC: Katherine Jamison, PharmD, BCPS, AAHIVP, Allison Kirstie French, PharmD, Nick Weatherton, PharmD, BCPS, BCACP, BCGP; Portland VA: Kimberly Tamura Mackay, PharmD, Johanna Peragine, PharmD; Eisenhower VAMC: Emily Potter, PharmD, BCPS; VA Connecticut: Brian Kotansky, PharmD, BCPS, Ann Fisher, MD, Van Vu, PharmD; New Orleans: Ngoc-tuyet Ngo, PharmD; St. Louis VA: Danielle Skouby, PharmD, BCPS; Fargo VA HCS: Jessica Dietz, PharmD, BCPS; Albuquerque, New Mexico VA HCS VA: Valeria Ilieva, MD, Tara Lindeman, PharmD; James A. Quillen VAMC: Marty Vannoy, PharmD, BCPS; Wilkes-Barre VAMC: Michael Surdy, PharmD, AAHIVP, Jill M. O'Donnell, PharmD, BCPS, BCGP, Tyler Young, PharmD; VA Puget Sound HCS: Jonathan Casavant, PharmD, BCPS; Gainesville VAMC: Joseph Pardo, PharmD, BCPS-AQ ID, AAHIVP,Michelle Lee, PharmD, Stephen Hare, PharmD; Fayetteville VAMC: Brian Leith, PharmD, BCPS, BCGP, Penny Peacock, PharmD, BCPS, Lindsey Cross, PharmD, BCACP; Pittsburgh VAMC: Amanda McQuillan, PharmD, BCPS; Cincinnati VAMC: Jason Hiett, PharmD, BCPS, Jeremy Hilty, PharmD, PhD, BCPS, Victoria Tate, PharmD, BCPS, Jesse Brown; Lisa Young PhamD, BCPS, AQ-ID, Jenna Lopez, PharmD; Saginaw VAMC: Kayla J. Houghteling, PharmD, BCPS, CDE, Rebecca Meagher, PharmD, Eric Szydlowski, PharmD; VA Central Iowa HCS: Jenny Phabmixay, PharmD, BCPS, Kimberly S. Redeker, PharmD, BCACP; Edward Hines VA: Ursula Patel, PharmD,

BCPS, AAHIVP, Kaitlyn Acosta, PharmD, Oluwabunmi Abraham, PharmD; Central California VA: Jon Malepsy, PharmD, Jerick San Mateo, PharmD, Christopher Lam, PharmD; Dorn VA: Alyssa M. Grill, PharmD, BCPS; VA San Diego Health System: Ariel Ma, PharmD, BCPS, AQ-ID, Charisma Urbiztondo, PharmD, Scott Johns, PharmD, BCPS, Veterans Health Care System of the Ozarks (Arkansas): Jennifer Cole, PharmD, BCPS, BCCCP, Carol Allred, PharmD, Michele Walker, PharmD, BCGP, Sioux Falls VA Health Care System: Andrea Aylward, PharmD, BCPS, Mackenzie Schreier, PharmD, Cassie Heisinger, PharmD

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**Table I. Patient Demographic, Provider, and Treatment Setting Characteristics**

| Characteristic, N (%) | All patients [a] (n=4,303) | Antibiotics Prescribed (n=2,907) | No Antibiotics Prescribed (n=1,396) | Sig. [b] |
|---|---|---|---|---|
| Age (y), Mean (± S.D.) | 50 (16) | 50 (16) | 49 (16) | 0.08 |
| Gender (Male) | 3,564 (83) | 2,449 (84) | 1,114 (80) | **<0.01** |
| Current smoker | 1,117 (26) | 839 (29) | 278 (20) | **<0.01** |
| Beta-lactam allergy | 517 (12) | 364 (13) | 153 (11) | 0.15 |
| **Vital Signs** | | | | |
| Temperature ≥ 101 F | 29 (<1) | 21 (<1) | 8 (<1) | 0.69 |
| HR > 90 beats / minute | 1,129 (26) | 758 (26) | 371 (27) | 0.74 |
| RR > 20 breaths / minute | 97 (2) | 73 (3) | 24 (2) | 0.12 |
| **Comorbid Conditions** | | | | |
| No comorbidities | 3,979 (92) | 2,673 (92) | 1,304 (93) | Reference [c] |
| 1 comorbidity | 270 (6) | 191 (7) | 79 (6) | 1.2 (0.9,1.5) |
| ≥2 comorbidity | 56 (1) | 43 (2) | 13 (<1) | 1.6 (0.9,3) |
| **Treating Provider** | | | | |
| Staff physician provider | 2,999 (70) | 2,101 (70) | 898 (30) | Reference [d] |
| Mid-level provider | 857 (20) | 632 (74) | 225 (26) | 1.2 (1.0,1.4) |
| Medical trainees | 351 (8) | 117 (33) | 234 (67) | 0.2 (0.2,0.3) |
| Other provider | 94 (2) | 55 (59) | 39 (42) | 0.6 (0.4,0.9) |
| **Treatment Setting** | | | | |
| Emergency department | 2,218 (52) | 1,570 (71) | 648 (29) | Reference [e] |
| Urgent care clinic | 640 (15) | 417 (65) | 223 (35) | 0.8 (0.6,0.9) |
| Primary care clinic | 1,356 (32) | 880 (65) | 476 (35) | 0.8 (0.7,0.9) |
| Other outpatient clinic | 89 (2.0) | 40 (45) | 49 (55) | 0.3 (0.2,0.5) |

[a]Not all observations for each variable were recorded resulting in missing data for select characteristics. Two patients lacked antibiotic prescribing information documented (n=4,303). Due to rounding, all percentages may not add up to 100%. Abbreviations: Years (y), Fahrenheit (F), heart rate (HR), respiratory rate (RR)

[b]Reported P-values compared patients with antibiotics prescribed and patients with no antibiotics prescribed.

[c]Comorbidities evaluated renal disease, diabetes, liver disease, chronic heart failure, and history of cerebrovascular accident/transient ischemic attack. Two patients in the no comorbidities category did not have documentation indicating whether antibiotics were prescribed recorded (n=3,977). Significance reported as the odds ratio (OR ± 95% CI) of receiving an antibiotic with no comorbidities as the reference group.

[d]Mid-level providers included physician assistants and nurse practitioners. Other providers included non-physician trainees, nurses, or providers that were unidentifiable. Four patients did not have type of provider recorded (n= 4,301). Significance reported as the odds ratio (OR ± 95% CI) of receiving an antibiotic with staff physician provider as the reference group.

[e]Other outpatient clinic included Women's clinic and select Community-Based Outreach Clinics (CBOC). Two patients did not have treatment setting recorded (n=4,303). Significance reported as the odds ratio (OR ± 95% CI) of receiving an antibiotic with Emergency Department as the reference group.

**Table II: Documentation of Diagnostic Criteria for Antibiotic Therapy in Patients with a Diagnosis of Rhinosinusitis or Pharyngitis[a]**

| **Acute Rhinosinusitis Symptoms, N (%)** | **All Patients** | **Received Antibiotics** | **Did not Receive Antibiotics** | **P-Value[b]** |
|---|---|---|---|---|
| All Patients | 715 (100) | 633 (89) | 82(12) | - |
| **Patients with ≥ 1 of the following rhinosinusitis symptoms or treatment criteria** | 567 (79) | 507 (80) | 60 (73) | 0.15 |
| Purulent nasal discharge | 144 (20) | 134 (21) | 10 (12) | 0.06 |
| Facial pain, pressure, or fullness | 443 (62) | 396 (63) | 47(57) | 0.36 |
| Prolonged (≥ 7 days)[c] | 284 (40) | 262 (41) | 22 (27) | **0.01** |
| Worsening (after > 4 days)[c] | 41 (6) | 38 (6) | 3 (4) | 0.39 |
| Severe (Fever ≥ 102˚F)[c] | 2 (<1) | 2 (<1) | 0 (<1) | 0.61 |
| **Antibiotic prescribing symptoms criteria met[d]** | 216(30) | 203 (32) | 13 (16) | **< 0.01** |
| **Acute Pharyngitis Symptoms, N (%)** | **All Patients** | **Received Antibiotics[b]** | **Did not Receive Antibiotics[b]** | **P-Value [c]** |
| All patients | 558 (100) | 384 (69) | 174(31) | - |
| Centor Criteria Score[e] | | | | |
| 0 or not documented | 213 (38) | 134 (35) | 79 (49 | **0.02** |
| 1 | 219 (39) | 148 (31) | 71 (41) | 0.61 |
| 2 | 96 (17) | 76 (20) | 20 (12) | **0.02** |
| 3 | 30 (6) | 26 (7) | 4 (2) | **0.03** |
| 4 | 0 (0) | 0 (0) | 0 (0) | - |
| 0-1 Centor criteria documented | 432(77) | 282(73) | 150 (86) | **<0.01** |
| ≥ 2 Centor criteria documented | 126 (23) | 102 (27) | 24 (14) | **<0.01** |
| No RADT or Throat Culture obtained | 373 (67) | 276 (72) | 97 (56) | **<0.01** |
| RADT or throat culture obtained | 185 (33) | 108 (28) | 77 (44) | **<0.01** |
| ≥ 2 Centor criteria documented and RADT or throat culture obtained | 53 (10) | 38 (10) | 15 (9) | 0.63 |
| Total RADT and throat cultures positive[f] | 33 (6) | 28 (7) | 5 (3) | **0.04** |
| Group A Streptococcus | 17 (3) | 14 (4) | 3 (2) | 0.22 |
| Group C or G Streptococcus | 8 (1) | 7 (2) | 1 (1) | 0.25 |

[a]Due to rounding, all percentages may not add up to 100%.

[b]Reported P-values compared patients with antibiotics prescribed and patients with no antibiotics prescribed.

[c]Symptoms categorized as prolonged, worsening, or severe could have been rhinosinusitis symptoms or non-rhinosinusitis symptoms.

[d]Antibiotic Prescribing Symptoms Criteria met based on documentation of purulent nasal discharge and/or facial pain or pressure AND any combination of prolonged symptoms, severe criteria, or worsening criteria was used to define antibiotic prescribing criteria.

[e]The Centor Criteria is a 4-point scale. Patients get a point for each of the following criteria they meet: temperature $\geq$101 ˚F, enlarged cervical nodes, tonsillar exudate, and absence of cough[17]

[f]Throat cultures were considered positive if there was growth of Group A, C, or G streptococcus reported.

## Table III. Follow-up Outcomes for Patients with Uncomplicated Acute Respiratory Tract Infections (ARIs)[a]

| Outcome | All Patients | | | Acute Pharyngitis | | | Acute Rhinosinusitis | | | Acute Bronchitis | | | URI-NOS | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Antibiotic Prescribed, n (%) | Antibiotic Withheld, n (%) | P-value | Antibiotic Prescribed, n (%) | Antibiotic Withheld, n (%) | P-value | Antibiotic Prescribed, n (%) | Antibiotic Withheld, n (%) | P-value | Antibiotic Prescribe, n (%) | Antibiotic Withheld, n (%) | P-value | Antibiotic Prescribed, n (%) | Antibiotic Withheld, n (%) | P-value |
| | n=2552 | n=1332 | | n=382 | n=174 | | n=630 | n=79 | | n=990 | n=158 | | n=550 | n=921 | |
| Unique ARI-related return encounter | 457 (18) | 247 (19) | 0.63 | 71 (19) | 34 (20) | 0.79 | 106 (17) | 22 (28) | **0.02** | 198 (20) | 35 (22) | 0.53 | 82 (15) | 156 (17) | 0.31 |
| 30-day ARI-related return visit | 248 (10) | 146 (11) | 0.22 | 37 (10) | 18 (10) | 0.81 | 57 (9) | 9 (11) | 0.50 | 108 (11) | 20 (13) | 0.52 | 46 (8) | 99 (11) | 0.14 |
| Unresolved/Worsening Symptoms | 185 (7) | 116 (9) | 0.10 | 31 (8) | 13 (8) | 0.79 | 40 (6) | 9 (11) | 0.10 | 80 (8) | 17 (11) | 0.26 | 34 (6) | 77 (8) | 0.13 |
| Infectious Complication | 7 (<1) | 3 (<1) | 0.77 | 1 (<1) | 1 (1) | 0.57 | 1 (<1) | 0 (<1) | 0.72 | 3 (<1) | 0 (<1) | 0.49 | 2 (<1) | 2 (<1) | 0.60 |
| Antibiotic Prescribed | 105 (4) | 84 (6) | **<0.01** | 18 (5) | 11 (6) | 0.43 | 29 (5) | 3 (4) | 00.75 | 39 (4) | 12 (8) | **0.04** | 19 (4) | 58 (6) | **0.02** |
| Telephone | 260 (10) | 122 (9) | 0.31 | 45 (12) | 21 (12) | 0.92 | 56 (9) | 15 (19) | **<0.01** | 115 (12) | 21 (13) | 0.55 | 44 (8) | 65 (7) | 0.50 |
| Patient Initiated | 81 (3) | 37 (3) | 0.49 | 15 (4) | 4 (2) | 0.33 | 15 (2) | 3 (4) | 0.45 | 37 (4) | 6 (4) | 0.97 | 14 (3) | 24 (3) | 0.94 |
| 30-day *C. difficile* infection | 1 (<1) | 1 (<1) | 0.64 | 0 (<1) | 0 (<1) | - | 0 (<1) | 0 (<1) | - | 0 (<1) | 0 (<1) | - | 1 (<1) | 1 (<1) | 0.71 |
| 30-day Hospitalization | 25 (1) | 8 (<1) | 0.22 | 8 (2) | 0 (<1) | **0.05** | 4 (<1) | 0 (<1) | 0.48 | 8 (1) | 0 (<1) | 0.26 | 5 (1) | 8 (1) | 0.94 |

[a]Due to rounding, all percentages may not add up to 100%.

**Table IV. Outcomes Associated with Appropriate and Inappropriate Antibiotic Management of Uncomplicated Acute Respiratory Tract Infections (ARIs)[a]**

| Outcome | Overall Management[b] | | | Antibiotics Withheld | | | Antibiotics Initiated | | | Antibiotic Selection[c] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Appropriate, n (%) | Inappropriate, n (%) | P-value | Appropriate, n (%) | Inappropriate, n (%) | P-value | Appropriate, n (%) | Inappropriate, n (%) | P-value | Appropriate, n (%) | Inappropriate, n (%) | P-value |
| | n=1497 | n=2387 | | n=1314 | n=18 | | n=230 | n=2322 | | n=165 | n=65 | |
| Unique ARI-related return encounter | 288 (19) | 416 (17) | 0.15 | 239 (18) | 8 (44) | **<0.01** | 54 (24) | 403 (17) | **0.02** | 41 (25) | 13 (20) | 0.43 |
| 30-day ARI-related return visit[d] | 163 (11) | 231 (10) | 0.22 | 142 (11) | 4 (22) | 0.12 | 24 (10) | 224 (10) | 0.70 | 17 (10) | 7 (12) | 0.92 |
| Unresolved/Worsening Symptoms | 127 (9) | 174 (7) | 0.18 | 113 (9) | 3 (17) | 0.23 | 17 (7) | 168 (7) | 0.93 | 11 (7) | 6 (9) | 0.50 |
| Infectious Complication | 3 (<1) | 7 (<1) | 0.58 | 3 (<1) | 0 (<1) | 0.84 | 0 (<1) | 7 (<1) | 0.40 | 0 (<1) | 0 (<1) | NA |
| Antibiotic Prescribed | 93 (6) | 96 (4) | **<0.01** | 82 (6) | 2 (11) | 0.40 | 12 (5) | 93 (4) | 0.38 | 9 (6) | 3 (5) | 0.80 |
| Telephone | 149 (10) | 233 (10) | 0.84 | 116 (9) | 6 (33) | **<0.01** | 35 (15) | 225 (10) | **0.01** | 27 (16) | 8 (12) | 0.44 |
| Patient Initiated | 44 (3) | 74 (3) | 0.78 | 35 (3) | 2 (11) | **0.03** | 12 (5) | 69 (3) | 0.06 | 7 (4) | 5 (8) | 0.29 |
| 30-day *C. difficile* infection | 1 (<1) | 1 (<1) | 0.74 | 1 (<1) | 0 (<1) | 0.91 | 0 (<1) | 1 (<1) | 0.75 | 0 (<1) | 0 (<1) | NA |
| 30-day Hospitalization | 9 (1) | 24 (1) | 0.18 | 8 (1) | 0 (<1) | 0.74 | 2 (1) | 23 (1) | 0.86 | 1 (<1) | 1 (2) | 0.49 |

[a]Due to rounding, all percentages may not add up to 100%.

[b]Overall management was deemed appropriate if antibiotics were appropriately withheld or if antibiotics were appropriately initiated and the appropriated antibiotic was selected

[c]Selection of antibiotic was only evaluated as appropriate or inappropriate if the patient's antibiotic was appropriately initiated. Since initiation and thus, selection, of antimicrobials is never appropriate for URI-NOS. Patients in the URI-NOS were only included in the Appropriate Overall Management Group.

[d]ARI-related return visits included urgent care, ED, and primary care return visit

**Figure I. Application of Inclusion and Exclusion Criteria for Acute Respiratory Tract Infection (ARI) Management Evaluation**

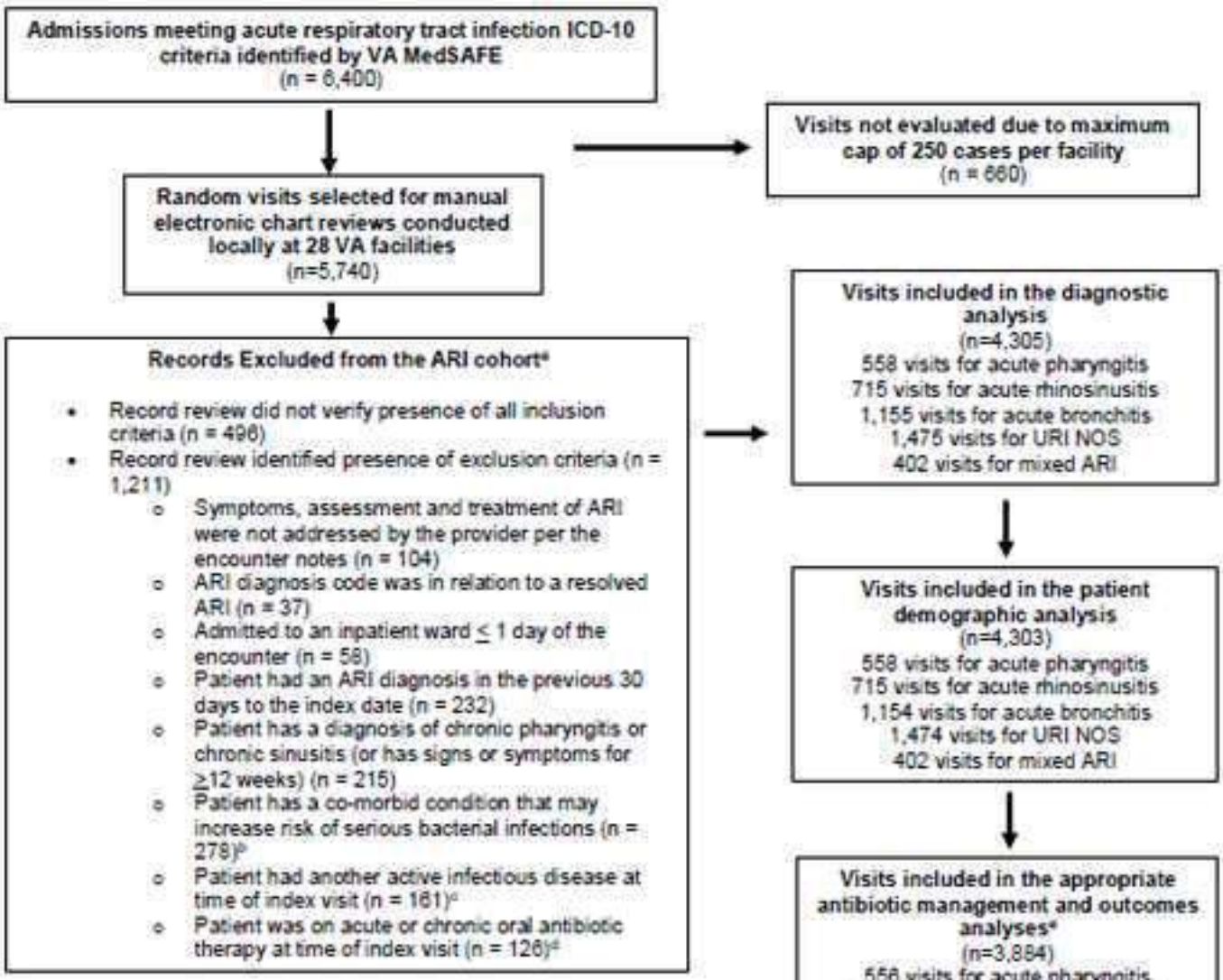


**Figure I Legend:**

*Visits may have met more than one criteria resulting in exclusion or preventing inclusion
[b]Co-morbid conditions include neoplasia, chronic lung disease (e.g., COPD, asthma), end-stage renal disease, solid organ transplantation, or other immunocompromised state (See supplementary Appendix A)
[c]Other infectious diseases that were not excluded were concurrent hepatitis, genital herpes, or superficial (cutaneous) fungal infections.
[d]Visits were not excluded if antibiotic agent was prescribed by a provider ≤2 days prior to encounter if the antibiotic was for ARI signs/symptoms
*Patients with mixed ARI diagnoses, delayed antibiotic prescriptions, or with missing antibiotic prescription data were excluded from the appropriate antibiotic management and outcomes analyses

| ICD Code | ICD Code Type | ARI Diagnosis Category |
|---|---|---|
| 460 | 9 | URI-NOS |
| 461 | 9 | Sinusitis |
| 461.1 | 9 | Sinusitis |
| 461.2 | 9 | Sinusitis |
| 461.3 | 9 | Sinusitis |
| 461.8 | 9 | Sinusitis |
| 461.9 | 9 | Sinusitis |
| 462 | 9 | Pharyngitis |
| 464 | 9 | URI-NOS |
| 465 | 9 | URI-NOS |
| 465.8 | 9 | URI-NOS |
| 465.9 | 9 | URI-NOS |
| 466 | 9 | Bronchitis bronchiolitis |
| 490 | 9 | Bronchitis bronchiolitis |
| J01.00 | 10 | Sinusitis |
| J01.10 | 10 | Sinusitis |
| J01.20 | 10 | Sinusitis |
| J01.30 | 10 | Sinusitis |
| J01.40 | 10 | Sinusitis |
| J01.90 | 10 | Sinusitis |
| J02.9 | 10 | Pharyngitis |
| J04.0 | 10 | URI-NOS |
| J06.0 | 10 | URI-NOS |
| J06.9 | 10 | URI-NOS |
| J20.9 | 10 | Bronchitis bronchiolitis |

| ICD Code Type | ICD Code | ICD Code Type | Exclusion Reason |
|---|---|---|---|
| 9 | 1 | 9 | Concurrent Infectious Disease |
| 9 | 1.1 | 9 | Concurrent Infectious Disease |
| 9 | 1.9 | 9 | Concurrent Infectious Disease |
| 9 | 2 | 9 | Concurrent Infectious Disease |
| 9 | 2.1 | 9 | Concurrent Infectious Disease |
| 9 | 2.2 | 9 | Concurrent Infectious Disease |
| 9 | 2.3 | 9 | Concurrent Infectious Disease |
| 9 | 2.9 | 9 | Concurrent Infectious Disease |
| 9 | 3 | 9 | Concurrent Infectious Disease |
| 9 | 3.1 | 9 | Concurrent Infectious Disease |
| 9 | 3.2 | 9 | Concurrent Infectious Disease |
| 9 | 3.21 | 9 | Concurrent Infectious Disease |
| 9 | 3.22 | 9 | Concurrent Infectious Disease |
| 9 | 3.23 | 9 | Concurrent Infectious Disease |
| 9 | 3.24 | 9 | Concurrent Infectious Disease |
| 9 | 3.29 | 9 | Concurrent Infectious Disease |
| 9 | 3.8 | 9 | Concurrent Infectious Disease |
| 9 | 3.9 | 9 | Concurrent Infectious Disease |
| 9 | 4 | 9 | Concurrent Infectious Disease |
| 9 | 4.1 | 9 | Concurrent Infectious Disease |
| 9 | 4.2 | 9 | Concurrent Infectious Disease |
| 9 | 4.3 | 9 | Concurrent Infectious Disease |
| 9 | 4.8 | 9 | Concurrent Infectious Disease |
| 9 | 4.9 | 9 | Concurrent Infectious Disease |
| 9 | 5 | 9 | Concurrent Infectious Disease |
| 9 | 5.1 | 9 | Concurrent Infectious Disease |
| 9 | 5.2 | 9 | Concurrent Infectious Disease |
| 9 | 5.3 | 9 | Concurrent Infectious Disease |
| 9 | 5.4 | 9 | Concurrent Infectious Disease |
| 9 | 5.8 | 9 | Concurrent Infectious Disease |
| 9 | 5.81 | 9 | Concurrent Infectious Disease |
| 9 | 5.89 | 9 | Concurrent Infectious Disease |
| 9 | 5.9 | 9 | Concurrent Infectious Disease |
| 9 | 6 | 9 | Concurrent Infectious Disease |
| 9 | 6.1 | 9 | Concurrent Infectious Disease |
| 9 | 6.2 | 9 | Concurrent Infectious Disease |
| 9 | 6.3 | 9 | Concurrent Infectious Disease |
| 9 | 6.4 | 9 | Concurrent Infectious Disease |
| 9 | 6.5 | 9 | Concurrent Infectious Disease |
| 9 | 6.6 | 9 | Concurrent Infectious Disease |
| 9 | 6.8 | 9 | Concurrent Infectious Disease |
| 9 | 6.9 | 9 | Concurrent Infectious Disease |
| 9 | 7 | 9 | Concurrent Infectious Disease |
| 9 | 7.1 | 9 | Concurrent Infectious Disease |
| 9 | 7.2 | 9 | Concurrent Infectious Disease |
| 9 | 7.3 | 9 | Concurrent Infectious Disease |

| | | | |
|---|---|---|---|
| 9 | 7.4 | 9 | Concurrent Infectious Disease |
| 9 | 7.5 | 9 | Concurrent Infectious Disease |
| 9 | 7.8 | 9 | Concurrent Infectious Disease |
| 9 | 7.9 | 9 | Concurrent Infectious Disease |
| 9 | 8 | 9 | Concurrent Infectious Disease |
| 9 | 8.01 | 9 | Concurrent Infectious Disease |
| 9 | 8.02 | 9 | Concurrent Infectious Disease |
| 9 | 8.03 | 9 | Concurrent Infectious Disease |
| 9 | 8.04 | 9 | Concurrent Infectious Disease |
| 9 | 8.09 | 9 | Concurrent Infectious Disease |
| 9 | 8.1 | 9 | Concurrent Infectious Disease |
| 9 | 8.2 | 9 | Concurrent Infectious Disease |
| 9 | 8.3 | 9 | Concurrent Infectious Disease |
| 9 | 8.41 | 9 | Concurrent Infectious Disease |
| 9 | 8.42 | 9 | Concurrent Infectious Disease |
| 9 | 8.43 | 9 | Concurrent Infectious Disease |
| 9 | 8.44 | 9 | Concurrent Infectious Disease |
| 9 | 8.45 | 9 | Concurrent Infectious Disease |
| 9 | 8.46 | 9 | Concurrent Infectious Disease |
| 9 | 8.47 | 9 | Concurrent Infectious Disease |
| 9 | 8.49 | 9 | Concurrent Infectious Disease |
| 9 | 8.5 | 9 | Concurrent Infectious Disease |
| 9 | 8.6 | 9 | Concurrent Infectious Disease |
| 9 | 8.61 | 9 | Concurrent Infectious Disease |
| 9 | 8.62 | 9 | Concurrent Infectious Disease |
| 9 | 8.63 | 9 | Concurrent Infectious Disease |
| 9 | 8.64 | 9 | Concurrent Infectious Disease |
| 9 | 8.65 | 9 | Concurrent Infectious Disease |
| 9 | 8.66 | 9 | Concurrent Infectious Disease |
| 9 | 8.67 | 9 | Concurrent Infectious Disease |
| 9 | 8.69 | 9 | Concurrent Infectious Disease |
| 9 | 8.8 | 9 | Concurrent Infectious Disease |
| 9 | 9 | 9 | Concurrent Infectious Disease |
| 9 | 9.1 | 9 | Concurrent Infectious Disease |
| 9 | 9.2 | 9 | Concurrent Infectious Disease |
| 9 | 9.3 | 9 | Concurrent Infectious Disease |
| 9 | 10 | 9 | Concurrent Infectious Disease |
| 9 | 10.01 | 9 | Concurrent Infectious Disease |
| 9 | 10.02 | 9 | Concurrent Infectious Disease |
| 9 | 10.03 | 9 | Concurrent Infectious Disease |
| 9 | 10.04 | 9 | Concurrent Infectious Disease |
| 9 | 10.05 | 9 | Concurrent Infectious Disease |
| 9 | 10.06 | 9 | Concurrent Infectious Disease |
| 9 | 10.1 | 9 | Concurrent Infectious Disease |
| 9 | 10.11 | 9 | Concurrent Infectious Disease |
| 9 | 10.12 | 9 | Concurrent Infectious Disease |
| 9 | 10.13 | 9 | Concurrent Infectious Disease |

| | | | |
|---|---|---|---|
| 9 | 10.14 | 9 | Concurrent Infectious Disease |
| 9 | 10.15 | 9 | Concurrent Infectious Disease |
| 9 | 10.16 | 9 | Concurrent Infectious Disease |
| 9 | 10.8 | 9 | Concurrent Infectious Disease |
| 9 | 10.81 | 9 | Concurrent Infectious Disease |
| 9 | 10.82 | 9 | Concurrent Infectious Disease |
| 9 | 10.83 | 9 | Concurrent Infectious Disease |
| 9 | 10.84 | 9 | Concurrent Infectious Disease |
| 9 | 10.85 | 9 | Concurrent Infectious Disease |
| 9 | 10.86 | 9 | Concurrent Infectious Disease |
| 9 | 10.9 | 9 | Concurrent Infectious Disease |
| 9 | 10.91 | 9 | Concurrent Infectious Disease |
| 9 | 10.92 | 9 | Concurrent Infectious Disease |
| 9 | 10.93 | 9 | Concurrent Infectious Disease |
| 9 | 10.94 | 9 | Concurrent Infectious Disease |
| 9 | 10.95 | 9 | Concurrent Infectious Disease |
| 9 | 10.96 | 9 | Concurrent Infectious Disease |
| 9 | 11 | 9 | Concurrent Infectious Disease |
| 9 | 11.01 | 9 | Concurrent Infectious Disease |
| 9 | 11.02 | 9 | Concurrent Infectious Disease |
| 9 | 11.03 | 9 | Concurrent Infectious Disease |
| 9 | 11.04 | 9 | Concurrent Infectious Disease |
| 9 | 11.05 | 9 | Concurrent Infectious Disease |
| 9 | 11.06 | 9 | Concurrent Infectious Disease |
| 9 | 11.1 | 9 | Concurrent Infectious Disease |
| 9 | 11.11 | 9 | Concurrent Infectious Disease |
| 9 | 11.12 | 9 | Concurrent Infectious Disease |
| 9 | 11.13 | 9 | Concurrent Infectious Disease |
| 9 | 11.14 | 9 | Concurrent Infectious Disease |
| 9 | 11.15 | 9 | Concurrent Infectious Disease |
| 9 | 11.16 | 9 | Concurrent Infectious Disease |
| 9 | 11.2 | 9 | Concurrent Infectious Disease |
| 9 | 11.21 | 9 | Concurrent Infectious Disease |
| 9 | 11.22 | 9 | Concurrent Infectious Disease |
| 9 | 11.23 | 9 | Concurrent Infectious Disease |
| 9 | 11.24 | 9 | Concurrent Infectious Disease |
| 9 | 11.25 | 9 | Concurrent Infectious Disease |
| 9 | 11.26 | 9 | Concurrent Infectious Disease |
| 9 | 11.3 | 9 | Concurrent Infectious Disease |
| 9 | 11.31 | 9 | Concurrent Infectious Disease |
| 9 | 11.32 | 9 | Concurrent Infectious Disease |
| 9 | 11.33 | 9 | Concurrent Infectious Disease |
| 9 | 11.34 | 9 | Concurrent Infectious Disease |
| 9 | 11.35 | 9 | Concurrent Infectious Disease |
| 9 | 11.36 | 9 | Concurrent Infectious Disease |
| 9 | 11.4 | 9 | Concurrent Infectious Disease |
| 9 | 11.41 | 9 | Concurrent Infectious Disease |

| | | | |
|---|---|---|---|
| 9 | 11.42 | 9 | Concurrent Infectious Disease |
| 9 | 11.43 | 9 | Concurrent Infectious Disease |
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| 9 | 223.3 | 9 | Malignancy |
| 9 | 223.81 | 9 | Malignancy |
| 9 | 223.89 | 9 | Malignancy |
| 9 | 223.9 | 9 | Malignancy |
| 9 | 224 | 9 | Malignancy |
| 9 | 224.1 | 9 | Malignancy |
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| 9 | 226 | 9 | Malignancy |
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| 9 | 228 | 9 | Malignancy |
| 9 | 228.01 | 9 | Malignancy |
| 9 | 228.02 | 9 | Malignancy |
| 9 | 228.03 | 9 | Malignancy |
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| 9 | 228.09 | 9 | Malignancy |
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| 9 | 230 | 9 | Malignancy |
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| 9 | 231.8 | 9 | Malignancy |
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| 9 | 233.3 | 9 | Malignancy |
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| 9 | 234 | 9 | Malignancy |
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| 9 | 235 | 9 | Malignancy |
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| 9 | 236.7 | 9 | Malignancy |
| 9 | 236.9 | 9 | Malignancy |
| 9 | 236.91 | 9 | Malignancy |
| 9 | 236.99 | 9 | Malignancy |
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| 9 | 237.2 | 9 | Malignancy |
| 9 | 237.3 | 9 | Malignancy |
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| 9 | 237.72 | 9 | Malignancy |
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| 9 | 237.79 | 9 | Malignancy |
| 9 | 237.9 | 9 | Malignancy |
| 9 | 238 | 9 | Malignancy |
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| 9 | 238.3 | 9 | Malignancy |
| 9 | 238.4 | 9 | Malignancy |
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| 9 | 238.6 | 9 | Malignancy |
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| 9 | 238.71 | 9 | Malignancy |
| 9 | 238.72 | 9 | Malignancy |
| 9 | 238.73 | 9 | Malignancy |
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| 9 | 238.75 | 9 | Malignancy |
| 9 | 238.76 | 9 | Malignancy |
| 9 | 238.77 | 9 | Malignancy |
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| 9 | 250.01 | 9 | Diabetes |
| 9 | 250.02 | 9 | Diabetes |
| 9 | 250.03 | 9 | Diabetes |
| 9 | 250.1 | 9 | Diabetes |
| 9 | 250.11 | 9 | Diabetes |
| 9 | 250.12 | 9 | Diabetes |
| 9 | 250.13 | 9 | Diabetes |
| 9 | 250.2 | 9 | Diabetes |
| 9 | 250.21 | 9 | Diabetes |
| 9 | 250.22 | 9 | Diabetes |
| 9 | 250.23 | 9 | Diabetes |
| 9 | 250.3 | 9 | Diabetes |
| 9 | 250.31 | 9 | Diabetes |
| 9 | 250.32 | 9 | Diabetes |
| 9 | 250.33 | 9 | Diabetes |
| 9 | 250.4 | 9 | Diabetes |
| 9 | 250.41 | 9 | Diabetes |
| 9 | 250.42 | 9 | Diabetes |
| 9 | 250.43 | 9 | Diabetes |
| 9 | 250.5 | 9 | Diabetes |
| 9 | 250.51 | 9 | Diabetes |

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| 9 | 250.53 | 9 | Diabetes |
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| 9 | 250.61 | 9 | Diabetes |
| 9 | 250.62 | 9 | Diabetes |
| 9 | 250.63 | 9 | Diabetes |
| 9 | 250.7 | 9 | Diabetes |
| 9 | 250.71 | 9 | Diabetes |
| 9 | 250.72 | 9 | Diabetes |
| 9 | 250.73 | 9 | Diabetes |
| 9 | 250.8 | 9 | Diabetes |
| 9 | 250.81 | 9 | Diabetes |
| 9 | 250.82 | 9 | Diabetes |
| 9 | 250.83 | 9 | Diabetes |
| 9 | 250.9 | 9 | Diabetes |
| 9 | 250.91 | 9 | Diabetes |
| 9 | 250.92 | 9 | Diabetes |
| 9 | 250.93 | 9 | Diabetes |
| 9 | 279.1 | 9 | Immunocompromised |
| 9 | 279.19 | 9 | Immunocompromised |
| 9 | 288 | 9 | Immunocompromised |
| 9 | 288.01 | 9 | Immunocompromised |
| 9 | 288.02 | 9 | Immunocompromised |
| 9 | 288.03 | 9 | Immunocompromised |
| 9 | 288.04 | 9 | Immunocompromised |
| 9 | 288.09 | 9 | Immunocompromised |
| 9 | 475 | 9 | Concurrent Infectious Disease |
| 9 | 478.24 | 9 | Concurrent Infectious Disease |
| 9 | 480 | 9 | Concurrent Infectious Disease |
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| 9 | 480.8 | 9 | Concurrent Infectious Disease |
| 9 | 480.9 | 9 | Concurrent Infectious Disease |
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| 9 | 482 | 9 | Concurrent Infectious Disease |
| 9 | 482.1 | 9 | Concurrent Infectious Disease |
| 9 | 482.2 | 9 | Concurrent Infectious Disease |
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| 9 | 482.32 | 9 | Concurrent Infectious Disease |
| 9 | 482.39 | 9 | Concurrent Infectious Disease |
| 9 | 482.4 | 9 | Concurrent Infectious Disease |
| 9 | 482.41 | 9 | Concurrent Infectious Disease |
| 9 | 482.42 | 9 | Concurrent Infectious Disease |
| 9 | 482.49 | 9 | Concurrent Infectious Disease |
| 9 | 482.8 | 9 | Concurrent Infectious Disease |

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| 9 | 482.81 | 9 | Concurrent Infectious Disease |
| 9 | 482.82 | 9 | Concurrent Infectious Disease |
| 9 | 482.83 | 9 | Concurrent Infectious Disease |
| 9 | 482.84 | 9 | Concurrent Infectious Disease |
| 9 | 482.89 | 9 | Concurrent Infectious Disease |
| 9 | 482.9 | 9 | Concurrent Infectious Disease |
| 9 | 483 | 9 | Concurrent Infectious Disease |
| 9 | 483.1 | 9 | Concurrent Infectious Disease |
| 9 | 483.8 | 9 | Concurrent Infectious Disease |
| 9 | 484.1 | 9 | Concurrent Infectious Disease |
| 9 | 484.3 | 9 | Concurrent Infectious Disease |
| 9 | 484.5 | 9 | Concurrent Infectious Disease |
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| 9 | 485 | 9 | Concurrent Infectious Disease |
| 9 | 486 | 9 | Concurrent Infectious Disease |
| 9 | 487 | 9 | Concurrent Infectious Disease |
| 9 | 487.1 | 9 | Concurrent Infectious Disease |
| 9 | 487.8 | 9 | Concurrent Infectious Disease |
| 9 | 488 | 9 | Concurrent Infectious Disease |
| 9 | 488.01 | 9 | Concurrent Infectious Disease |
| 9 | 488.02 | 9 | Concurrent Infectious Disease |
| 9 | 488.09 | 9 | Concurrent Infectious Disease |
| 9 | 488.1 | 9 | Concurrent Infectious Disease |
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| 9 | 488.12 | 9 | Concurrent Infectious Disease |
| 9 | 488.19 | 9 | Concurrent Infectious Disease |
| 9 | 488.81 | 9 | Concurrent Infectious Disease |
| 9 | 488.82 | 9 | Concurrent Infectious Disease |
| 9 | 488.89 | 9 | Concurrent Infectious Disease |
| 9 | 491 | 9 | Chronic Pulmonary Disorder |
| 9 | 491.1 | 9 | Chronic Pulmonary Disorder |
| 9 | 491.2 | 9 | Chronic Pulmonary Disorder |
| 9 | 491.21 | 9 | Chronic Pulmonary Disorder |
| 9 | 491.22 | 9 | Chronic Pulmonary Disorder |
| 9 | 491.8 | 9 | Chronic Pulmonary Disorder |
| 9 | 491.9 | 9 | Chronic Pulmonary Disorder |
| 9 | 492 | 9 | Chronic Pulmonary Disorder |
| 9 | 492.8 | 9 | Chronic Pulmonary Disorder |
| 9 | 493 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.01 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.02 | 9 | Chronic Pulmonary Disorder |
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| 9 | 493.11 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.12 | 9 | Chronic Pulmonary Disorder |
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| 9 | 493.21 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.22 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.81 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.82 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.9 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.91 | 9 | Chronic Pulmonary Disorder |
| 9 | 493.92 | 9 | Chronic Pulmonary Disorder |
| 9 | 494 | 9 | Chronic Pulmonary Disorder |
| 9 | 494.1 | 9 | Chronic Pulmonary Disorder |
| 9 | 495 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.1 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.2 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.3 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.4 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.5 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.6 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.7 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.8 | 9 | Chronic Pulmonary Disorder |
| 9 | 495.9 | 9 | Chronic Pulmonary Disorder |
| 9 | 496 | 9 | Chronic Pulmonary Disorder |
| 9 | 528.3 | 9 | Concurrent Infectious Disease |
| 9 | 585.6 | 9 | ESRD |
| 9 | 590.1 | 9 | Concurrent Infectious Disease |
| 9 | 590.11 | 9 | Concurrent Infectious Disease |
| 9 | 590.2 | 9 | Concurrent Infectious Disease |
| 9 | 590.3 | 9 | Concurrent Infectious Disease |
| 9 | 590.8 | 9 | Concurrent Infectious Disease |
| 9 | 590.81 | 9 | Concurrent Infectious Disease |
| 9 | 590.9 | 9 | Concurrent Infectious Disease |
| 9 | 595 | 9 | Concurrent Infectious Disease |
| 9 | 595.9 | 9 | Concurrent Infectious Disease |
| 9 | 599 | 9 | Concurrent Infectious Disease |
| 9 | 681 | 9 | Concurrent Infectious Disease |
| 9 | 681.01 | 9 | Concurrent Infectious Disease |
| 9 | 681.02 | 9 | Concurrent Infectious Disease |
| 9 | 681.1 | 9 | Concurrent Infectious Disease |
| 9 | 681.11 | 9 | Concurrent Infectious Disease |
| 9 | 681.9 | 9 | Concurrent Infectious Disease |
| 9 | 682 | 9 | Concurrent Infectious Disease |
| 9 | 682.1 | 9 | Concurrent Infectious Disease |
| 9 | 682.2 | 9 | Concurrent Infectious Disease |
| 9 | 682.3 | 9 | Concurrent Infectious Disease |
| 9 | 682.4 | 9 | Concurrent Infectious Disease |
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| 9 | 682.7 | 9 | Concurrent Infectious Disease |
| 9 | 682.8 | 9 | Concurrent Infectious Disease |

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| 9 | 682.9 | 9 | Concurrent Infectious Disease |
| 9 | 683 | 9 | Concurrent Infectious Disease |
| 9 | 686 | 9 | Concurrent Infectious Disease |
| 9 | 686.01 | 9 | Concurrent Infectious Disease |
| 9 | 686.09 | 9 | Concurrent Infectious Disease |
| 9 | 686.1 | 9 | Concurrent Infectious Disease |
| 9 | 686.8 | 9 | Concurrent Infectious Disease |
| 9 | 686.9 | 9 | Concurrent Infectious Disease |
| 9 | 728.86 | 9 | Concurrent Infectious Disease |
| 9 | 792.5 | 9 | Concurrent Infectious Disease |
| 9 | 795.71 | 9 | Immunocompromised |
| 9 | 996.81 | 9 | Immunocompromised |
| 9 | 996.82 | 9 | Immunocompromised |
| 9 | 996.83 | 9 | Immunocompromised |
| 9 | 996.84 | 9 | Immunocompromised |
| 9 | 996.85 | 9 | Immunocompromised |
| 9 | 996.86 | 9 | Immunocompromised |
| 9 | 996.87 | 9 | Immunocompromised |
| 10 | A00.0 | 10 | Concurrent Infectious Disease |
| 10 | A00.1 | 10 | Concurrent Infectious Disease |
| 10 | A00.9 | 10 | Concurrent Infectious Disease |
| 10 | A01.00 | 10 | Concurrent Infectious Disease |
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| 10 | A01.3 | 10 | Concurrent Infectious Disease |
| 10 | A01.4 | 10 | Concurrent Infectious Disease |
| 10 | A02.0 | 10 | Concurrent Infectious Disease |
| 10 | A02.1 | 10 | Concurrent Infectious Disease |
| 10 | A02.20 | 10 | Concurrent Infectious Disease |
| 10 | A02.21 | 10 | Concurrent Infectious Disease |
| 10 | A02.22 | 10 | Concurrent Infectious Disease |
| 10 | A02.23 | 10 | Concurrent Infectious Disease |
| 10 | A02.24 | 10 | Concurrent Infectious Disease |
| 10 | A02.29 | 10 | Concurrent Infectious Disease |
| 10 | A02.8 | 10 | Concurrent Infectious Disease |
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| 10 | A03.0 | 10 | Concurrent Infectious Disease |
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| 10 | A03.2 | 10 | Concurrent Infectious Disease |
| 10 | A03.3 | 10 | Concurrent Infectious Disease |
| 10 | A03.8 | 10 | Concurrent Infectious Disease |
| 10 | A03.9 | 10 | Concurrent Infectious Disease |
| 10 | A04.0 | 10 | Concurrent Infectious Disease |
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| 10 | A04.4 | 10 | Concurrent Infectious Disease |

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| 10 | A04.9 | 10 | Concurrent Infectious Disease |
| 10 | A05.0 | 10 | Concurrent Infectious Disease |
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| 10 | A05.3 | 10 | Concurrent Infectious Disease |
| 10 | A05.4 | 10 | Concurrent Infectious Disease |
| 10 | A05.5 | 10 | Concurrent Infectious Disease |
| 10 | A05.8 | 10 | Concurrent Infectious Disease |
| 10 | A05.9 | 10 | Concurrent Infectious Disease |
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| 10 | A06.1 | 10 | Concurrent Infectious Disease |
| 10 | A06.2 | 10 | Concurrent Infectious Disease |
| 10 | A06.4 | 10 | Concurrent Infectious Disease |
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| 10 | A06.6 | 10 | Concurrent Infectious Disease |
| 10 | A06.7 | 10 | Concurrent Infectious Disease |
| 10 | A06.89 | 10 | Concurrent Infectious Disease |
| 10 | A06.9 | 10 | Concurrent Infectious Disease |
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| 10 | A07.4 | 10 | Concurrent Infectious Disease |
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| 10 | A15.0 | 10 | Concurrent Infectious Disease |
| 10 | A15.4 | 10 | Concurrent Infectious Disease |
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| 10 | A15.7 | 10 | Concurrent Infectious Disease |
| 10 | A15.8 | 10 | Concurrent Infectious Disease |
| 10 | A17.0 | 10 | Concurrent Infectious Disease |
| 10 | A17.1 | 10 | Concurrent Infectious Disease |
| 10 | A17.81 | 10 | Concurrent Infectious Disease |

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| 10 | A17.82 | 10 | Concurrent Infectious Disease |
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| 10 | A18.02 | 10 | Concurrent Infectious Disease |
| 10 | A18.03 | 10 | Concurrent Infectious Disease |
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| 10 | A18.16 | 10 | Concurrent Infectious Disease |
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| 10 | A18.18 | 10 | Concurrent Infectious Disease |
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| 10 | A18.31 | 10 | Concurrent Infectious Disease |
| 10 | A18.32 | 10 | Concurrent Infectious Disease |
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| 10 | A18.50 | 10 | Concurrent Infectious Disease |
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| 10 | A18.52 | 10 | Concurrent Infectious Disease |
| 10 | A18.53 | 10 | Concurrent Infectious Disease |
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| 10 | A18.59 | 10 | Concurrent Infectious Disease |
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| 10 | A21.8 | 10 | Concurrent Infectious Disease |

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| 10 | A22.9 | 10 | Concurrent Infectious Disease |
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| 10 | A23.9 | 10 | Concurrent Infectious Disease |
| 10 | A24.0 | 10 | Concurrent Infectious Disease |
| 10 | A24.3 | 10 | Concurrent Infectious Disease |
| 10 | A24.9 | 10 | Concurrent Infectious Disease |
| 10 | A25.0 | 10 | Concurrent Infectious Disease |
| 10 | A25.1 | 10 | Concurrent Infectious Disease |
| 10 | A25.9 | 10 | Concurrent Infectious Disease |
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| 10 | A26.8 | 10 | Concurrent Infectious Disease |
| 10 | A26.9 | 10 | Concurrent Infectious Disease |
| 10 | A27.0 | 10 | Concurrent Infectious Disease |
| 10 | A27.81 | 10 | Concurrent Infectious Disease |
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| 10 | A31.0 | 10 | Concurrent Infectious Disease |
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| 10 | A31.9 | 10 | Concurrent Infectious Disease |
| 10 | A32.11 | 10 | Concurrent Infectious Disease |
| 10 | A32.12 | 10 | Concurrent Infectious Disease |
| 10 | A32.7 | 10 | Concurrent Infectious Disease |
| 10 | A32.81 | 10 | Concurrent Infectious Disease |
| 10 | A32.89 | 10 | Concurrent Infectious Disease |
| 10 | A32.9 | 10 | Concurrent Infectious Disease |

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| 10 | A35. | 10 | Concurrent Infectious Disease |
| 10 | A36.0 | 10 | Concurrent Infectious Disease |
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| 10 | D17.9 | 10 | Malignancy |
| 10 | D18.00 | 10 | Malignancy |
| 10 | D18.01 | 10 | Malignancy |

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| 10 | D18.02 | 10 | Malignancy |
| 10 | D18.03 | 10 | Malignancy |
| 10 | D18.09 | 10 | Malignancy |
| 10 | D18.1 | 10 | Malignancy |
| 10 | D19.0 | 10 | Malignancy |
| 10 | D20.0 | 10 | Malignancy |
| 10 | D20.1 | 10 | Malignancy |
| 10 | D21.0 | 10 | Malignancy |
| 10 | D21.10 | 10 | Malignancy |
| 10 | D21.20 | 10 | Malignancy |
| 10 | D21.3 | 10 | Malignancy |
| 10 | D21.4 | 10 | Malignancy |
| 10 | D21.5 | 10 | Malignancy |
| 10 | D21.6 | 10 | Malignancy |
| 10 | D21.9 | 10 | Malignancy |
| 10 | D22.9 | 10 | Malignancy |
| 10 | D23.0 | 10 | Malignancy |
| 10 | D23.10 | 10 | Malignancy |
| 10 | D23.20 | 10 | Malignancy |
| 10 | D23.30 | 10 | Malignancy |
| 10 | D23.39 | 10 | Malignancy |
| 10 | D23.4 | 10 | Malignancy |
| 10 | D23.5 | 10 | Malignancy |
| 10 | D23.60 | 10 | Malignancy |
| 10 | D23.70 | 10 | Malignancy |
| 10 | D23.9 | 10 | Malignancy |
| 10 | D24.1 | 10 | Malignancy |
| 10 | D25.0 | 10 | Malignancy |
| 10 | D25.1 | 10 | Malignancy |
| 10 | D25.2 | 10 | Malignancy |
| 10 | D25.9 | 10 | Malignancy |
| 10 | D26.0 | 10 | Malignancy |
| 10 | D26.1 | 10 | Malignancy |
| 10 | D26.7 | 10 | Malignancy |
| 10 | D26.9 | 10 | Malignancy |
| 10 | D27.9 | 10 | Malignancy |
| 10 | D28.0 | 10 | Malignancy |
| 10 | D28.1 | 10 | Malignancy |
| 10 | D28.2 | 10 | Malignancy |
| 10 | D28.7 | 10 | Malignancy |
| 10 | D28.9 | 10 | Malignancy |
| 10 | D29.0 | 10 | Malignancy |
| 10 | D29.1 | 10 | Malignancy |
| 10 | D29.20 | 10 | Malignancy |
| 10 | D29.30 | 10 | Malignancy |
| 10 | D29.4 | 10 | Malignancy |
| 10 | D29.8 | 10 | Malignancy |

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| 10 D29.9 | 10 Malignancy |
| 10 D30.00 | 10 Malignancy |
| 10 D30.10 | 10 Malignancy |
| 10 D30.20 | 10 Malignancy |
| 10 D30.3 | 10 Malignancy |
| 10 D30.4 | 10 Malignancy |
| 10 D30.8 | 10 Malignancy |
| 10 D30.9 | 10 Malignancy |
| 10 D31.00 | 10 Malignancy |
| 10 D31.10 | 10 Malignancy |
| 10 D31.20 | 10 Malignancy |
| 10 D31.30 | 10 Malignancy |
| 10 D31.40 | 10 Malignancy |
| 10 D31.50 | 10 Malignancy |
| 10 D31.60 | 10 Malignancy |
| 10 D31.90 | 10 Malignancy |
| 10 D32.0 | 10 Malignancy |
| 10 D32.1 | 10 Malignancy |
| 10 D32.9 | 10 Malignancy |
| 10 D33.2 | 10 Malignancy |
| 10 D33.3 | 10 Malignancy |
| 10 D33.4 | 10 Malignancy |
| 10 D33.7 | 10 Malignancy |
| 10 D33.9 | 10 Malignancy |
| 10 D34. | 10 Malignancy |
| 10 D35.00 | 10 Malignancy |
| 10 D35.1 | 10 Malignancy |
| 10 D35.2 | 10 Malignancy |
| 10 D35.3 | 10 Malignancy |
| 10 D35.4 | 10 Malignancy |
| 10 D35.5 | 10 Malignancy |
| 10 D35.6 | 10 Malignancy |
| 10 D35.7 | 10 Malignancy |
| 10 D35.9 | 10 Malignancy |
| 10 D36.0 | 10 Malignancy |
| 10 D36.7 | 10 Malignancy |
| 10 D36.9 | 10 Malignancy |
| 10 D37.01 | 10 Malignancy |
| 10 D37.02 | 10 Malignancy |
| 10 D37.030 | 10 Malignancy |
| 10 D37.031 | 10 Malignancy |
| 10 D37.032 | 10 Malignancy |
| 10 D37.039 | 10 Malignancy |
| 10 D37.04 | 10 Malignancy |
| 10 D37.05 | 10 Malignancy |
| 10 D37.1 | 10 Malignancy |
| 10 D37.2 | 10 Malignancy |

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| 10 | D37.4 | 10 | Malignancy |
| 10 | D37.5 | 10 | Malignancy |
| 10 | D37.6 | 10 | Malignancy |
| 10 | D37.8 | 10 | Malignancy |
| 10 | D37.9 | 10 | Malignancy |
| 10 | D38.0 | 10 | Malignancy |
| 10 | D38.1 | 10 | Malignancy |
| 10 | D38.2 | 10 | Malignancy |
| 10 | D38.3 | 10 | Malignancy |
| 10 | D38.4 | 10 | Malignancy |
| 10 | D38.5 | 10 | Malignancy |
| 10 | D38.6 | 10 | Malignancy |
| 10 | D39.0 | 10 | Malignancy |
| 10 | D39.10 | 10 | Malignancy |
| 10 | D39.2 | 10 | Malignancy |
| 10 | D39.8 | 10 | Malignancy |
| 10 | D39.9 | 10 | Malignancy |
| 10 | D3A.00 | 10 | Malignancy |
| 10 | D3A.010 | 10 | Malignancy |
| 10 | D3A.011 | 10 | Malignancy |
| 10 | D3A.012 | 10 | Malignancy |
| 10 | D3A.019 | 10 | Malignancy |
| 10 | D3A.020 | 10 | Malignancy |
| 10 | D3A.021 | 10 | Malignancy |
| 10 | D3A.022 | 10 | Malignancy |
| 10 | D3A.023 | 10 | Malignancy |
| 10 | D3A.024 | 10 | Malignancy |
| 10 | D3A.025 | 10 | Malignancy |
| 10 | D3A.026 | 10 | Malignancy |
| 10 | D3A.029 | 10 | Malignancy |
| 10 | D3A.090 | 10 | Malignancy |
| 10 | D3A.091 | 10 | Malignancy |
| 10 | D3A.092 | 10 | Malignancy |
| 10 | D3A.093 | 10 | Malignancy |
| 10 | D3A.094 | 10 | Malignancy |
| 10 | D3A.095 | 10 | Malignancy |
| 10 | D3A.096 | 10 | Malignancy |
| 10 | D3A.098 | 10 | Malignancy |
| 10 | D40.0 | 10 | Malignancy |
| 10 | D40.10 | 10 | Malignancy |
| 10 | D40.8 | 10 | Malignancy |
| 10 | D40.9 | 10 | Malignancy |
| 10 | D41.00 | 10 | Malignancy |
| 10 | D41.20 | 10 | Malignancy |
| 10 | D41.4 | 10 | Malignancy |
| 10 | D41.8 | 10 | Malignancy |
| 10 | D41.9 | 10 | Malignancy |

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| 10 D42.0 | 10 Malignancy |
| 10 D42.1 | 10 Malignancy |
| 10 D42.9 | 10 Malignancy |
| 10 D43.2 | 10 Malignancy |
| 10 D43.3 | 10 Malignancy |
| 10 D43.4 | 10 Malignancy |
| 10 D43.8 | 10 Malignancy |
| 10 D43.9 | 10 Malignancy |
| 10 D44.0 | 10 Malignancy |
| 10 D44.10 | 10 Malignancy |
| 10 D44.2 | 10 Malignancy |
| 10 D44.3 | 10 Malignancy |
| 10 D44.4 | 10 Malignancy |
| 10 D44.5 | 10 Malignancy |
| 10 D44.6 | 10 Malignancy |
| 10 D44.7 | 10 Malignancy |
| 10 D44.9 | 10 Malignancy |
| 10 D45. | 10 Malignancy |
| 10 D46.0 | 10 Malignancy |
| 10 D46.1 | 10 Malignancy |
| 10 D46.20 | 10 Malignancy |
| 10 D46.21 | 10 Malignancy |
| 10 D46.22 | 10 Malignancy |
| 10 D46.9 | 10 Malignancy |
| 10 D46.A | 10 Malignancy |
| 10 D46.B | 10 Malignancy |
| 10 D46.C | 10 Malignancy |
| 10 D47.0 | 10 Malignancy |
| 10 D47.1 | 10 Malignancy |
| 10 D47.3 | 10 Malignancy |
| 10 D47.9 | 10 Malignancy |
| 10 D47.Z1 | 10 Malignancy |
| 10 D47.Z9 | 10 Malignancy |
| 10 D48.0 | 10 Malignancy |
| 10 D48.1 | 10 Malignancy |
| 10 D48.3 | 10 Malignancy |
| 10 D48.4 | 10 Malignancy |
| 10 D48.5 | 10 Malignancy |
| 10 D48.60 | 10 Malignancy |
| 10 D48.7 | 10 Malignancy |
| 10 D48.9 | 10 Malignancy |
| 10 D70.0 | 10 Immunocompromised |
| 10 D70.1 | 10 Immunocompromised |
| 10 D70.2 | 10 Immunocompromised |
| 10 D70.3 | 10 Immunocompromised |
| 10 D70.4 | 10 Immunocompromised |
| 10 D70.8 | 10 Immunocompromised |

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| 10 D70.9 | 10 Immunocompromised |
| 10 D80.8 | 10 Immunocompromised |
| 10 D83.1 | 10 Immunocompromised |
| 10 D86.9 | 10 Immunocompromised |
| 10 E10.10 | 10 Diabetes |
| 10 E10.11 | 10 Diabetes |
| 10 E10.21 | 10 Diabetes |
| 10 E10.29 | 10 Diabetes |
| 10 E10.311 | 10 Diabetes |
| 10 E10.319 | 10 Diabetes |
| 10 E10.36 | 10 Diabetes |
| 10 E10.39 | 10 Diabetes |
| 10 E10.40 | 10 Diabetes |
| 10 E10.51 | 10 Diabetes |
| 10 E10.618 | 10 Diabetes |
| 10 E10.620 | 10 Diabetes |
| 10 E10.621 | 10 Diabetes |
| 10 E10.622 | 10 Diabetes |
| 10 E10.628 | 10 Diabetes |
| 10 E10.630 | 10 Diabetes |
| 10 E10.638 | 10 Diabetes |
| 10 E10.641 | 10 Diabetes |
| 10 E10.649 | 10 Diabetes |
| 10 E10.65 | 10 Diabetes |
| 10 E10.69 | 10 Diabetes |
| 10 E10.8 | 10 Diabetes |
| 10 E10.9 | 10 Diabetes |
| 10 E11.00 | 10 Diabetes |
| 10 E11.01 | 10 Diabetes |
| 10 E11.21 | 10 Diabetes |
| 10 E11.29 | 10 Diabetes |
| 10 E11.311 | 10 Diabetes |
| 10 E11.319 | 10 Diabetes |
| 10 E11.36 | 10 Diabetes |
| 10 E11.39 | 10 Diabetes |
| 10 E11.40 | 10 Diabetes |
| 10 E11.51 | 10 Diabetes |
| 10 E11.618 | 10 Diabetes |
| 10 E11.620 | 10 Diabetes |
| 10 E11.621 | 10 Diabetes |
| 10 E11.622 | 10 Diabetes |
| 10 E11.628 | 10 Diabetes |
| 10 E11.630 | 10 Diabetes |
| 10 E11.638 | 10 Diabetes |
| 10 E11.641 | 10 Diabetes |
| 10 E11.649 | 10 Diabetes |
| 10 E11.65 | 10 Diabetes |

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|---|---|---|---|
| 10 | E11.69 | 10 | Diabetes |
| 10 | E11.8 | 10 | Diabetes |
| 10 | E11.9 | 10 | Diabetes |
| 10 | E13.10 | 10 | Diabetes |
| 10 | E83.2 | 10 | Diabetes |
| 10 | G02. | 10 | Immunocompromised |
| 10 | G14. | 10 | Concurrent Infectious Disease |
| 10 | H32. | 10 | Concurrent Infectious Disease |
| 10 | I32. | 10 | Concurrent Infectious Disease |
| 10 | I39. | 10 | Concurrent Infectious Disease |
| 10 | J02.0 | 10 | Concurrent Infectious Disease |
| 10 | J03.00 | 10 | Concurrent Infectious Disease |
| 10 | J09.X1 | 10 | Concurrent Infectious Disease |
| 10 | J09.X2 | 10 | Concurrent Infectious Disease |
| 10 | J09.X3 | 10 | Concurrent Infectious Disease |
| 10 | J09.X9 | 10 | Concurrent Infectious Disease |
| 10 | J10.08 | 10 | Concurrent Infectious Disease |
| 10 | J10.1 | 10 | Concurrent Infectious Disease |
| 10 | J11.00 | 10 | Concurrent Infectious Disease |
| 10 | J11.1 | 10 | Concurrent Infectious Disease |
| 10 | J11.2 | 10 | Concurrent Infectious Disease |
| 10 | J11.81 | 10 | Concurrent Infectious Disease |
| 10 | J11.89 | 10 | Concurrent Infectious Disease |
| 10 | J12.0 | 10 | Concurrent Infectious Disease |
| 10 | J12.1 | 10 | Concurrent Infectious Disease |
| 10 | J12.2 | 10 | Concurrent Infectious Disease |
| 10 | J12.81 | 10 | Concurrent Infectious Disease |
| 10 | J12.89 | 10 | Concurrent Infectious Disease |
| 10 | J12.9 | 10 | Concurrent Infectious Disease |
| 10 | J13. | 10 | Concurrent Infectious Disease |
| 10 | J14. | 10 | Concurrent Infectious Disease |
| 10 | J15.0 | 10 | Concurrent Infectious Disease |
| 10 | J15.1 | 10 | Concurrent Infectious Disease |
| 10 | J15.20 | 10 | Concurrent Infectious Disease |
| 10 | J15.211 | 10 | Concurrent Infectious Disease |
| 10 | J15.212 | 10 | Concurrent Infectious Disease |
| 10 | J15.29 | 10 | Concurrent Infectious Disease |
| 10 | J15.3 | 10 | Concurrent Infectious Disease |
| 10 | J15.4 | 10 | Concurrent Infectious Disease |
| 10 | J15.5 | 10 | Concurrent Infectious Disease |
| 10 | J15.6 | 10 | Concurrent Infectious Disease |
| 10 | J15.7 | 10 | Concurrent Infectious Disease |
| 10 | J15.8 | 10 | Concurrent Infectious Disease |
| 10 | J15.9 | 10 | Concurrent Infectious Disease |
| 10 | J16.0 | 10 | Concurrent Infectious Disease |
| 10 | J16.8 | 10 | Concurrent Infectious Disease |
| 10 | J17. | 10 | Concurrent Infectious Disease |

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| 10 | J18.0 | 10 | Concurrent Infectious Disease |
| 10 | J18.1 | 10 | Concurrent Infectious Disease |
| 10 | J18.9 | 10 | Concurrent Infectious Disease |
| 10 | J32.9 | 10 | Chronic Sinusitis, Pharyngitis, or Bronchitis |
| 10 | J36. | 10 | Concurrent Infectious Disease |
| 10 | J39.0 | 10 | Concurrent Infectious Disease |
| 10 | J41.0 | 10 | Chronic Sinusitis, Pharyngitis, or Bronchitis |
| 10 | J41.1 | 10 | Chronic Sinusitis, Pharyngitis, or Bronchitis |
| 10 | J41.8 | 10 | Chronic Sinusitis, Pharyngitis, or Bronchitis |
| 10 | J42. | 10 | Chronic Sinusitis, Pharyngitis, or Bronchitis |
| 10 | J43.9 | 10 | Chronic Pulmonary Disorder |
| 10 | J44.0 | 10 | Chronic Pulmonary Disorder |
| 10 | J44.1 | 10 | Chronic Pulmonary Disorder |
| 10 | J44.9 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.20 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.21 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.22 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.901 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.902 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.909 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.990 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.991 | 10 | Chronic Pulmonary Disorder |
| 10 | J45.998 | 10 | Chronic Pulmonary Disorder |
| 10 | J47.1 | 10 | Chronic Pulmonary Disorder |
| 10 | J47.9 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.0 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.1 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.2 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.3 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.4 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.5 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.6 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.7 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.8 | 10 | Chronic Pulmonary Disorder |
| 10 | J67.9 | 10 | Chronic Pulmonary Disorder |
| 10 | K12.2 | 10 | Concurrent Infectious Disease |
| 10 | K31.7 | 10 | Concurrent Infectious Disease |
| 10 | K63.5 | 10 | Concurrent Infectious Disease |
| 10 | K90.81 | 10 | Concurrent Infectious Disease |
| 10 | L03.019 | 10 | Concurrent Infectious Disease |
| 10 | L03.029 | 10 | Concurrent Infectious Disease |
| 10 | L03.039 | 10 | Concurrent Infectious Disease |
| 10 | L03.049 | 10 | Concurrent Infectious Disease |
| 10 | L03.119 | 10 | Concurrent Infectious Disease |
| 10 | L03.129 | 10 | Concurrent Infectious Disease |
| 10 | L03.211 | 10 | Concurrent Infectious Disease |
| 10 | L03.212 | 10 | Concurrent Infectious Disease |

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| 10 | L03.221 | 10 | Concurrent Infectious Disease |
| 10 | L03.222 | 10 | Concurrent Infectious Disease |
| 10 | L03.317 | 10 | Concurrent Infectious Disease |
| 10 | L03.319 | 10 | Concurrent Infectious Disease |
| 10 | L03.329 | 10 | Concurrent Infectious Disease |
| 10 | L03.811 | 10 | Concurrent Infectious Disease |
| 10 | L03.818 | 10 | Concurrent Infectious Disease |
| 10 | L03.891 | 10 | Concurrent Infectious Disease |
| 10 | L03.898 | 10 | Concurrent Infectious Disease |
| 10 | L03.90 | 10 | Concurrent Infectious Disease |
| 10 | L03.91 | 10 | Concurrent Infectious Disease |
| 10 | L04.9 | 10 | Concurrent Infectious Disease |
| 10 | L08.0 | 10 | Concurrent Infectious Disease |
| 10 | L08.1 | 10 | Concurrent Infectious Disease |
| 10 | L08.89 | 10 | Concurrent Infectious Disease |
| 10 | L08.9 | 10 | Concurrent Infectious Disease |
| 10 | L44.4 | 10 | Concurrent Infectious Disease |
| 10 | L88. | 10 | Concurrent Infectious Disease |
| 10 | L94.6 | 10 | Concurrent Infectious Disease |
| 10 | L98.0 | 10 | Concurrent Infectious Disease |
| 10 | M02.30 | 10 | Concurrent Infectious Disease |
| 10 | M35.2 | 10 | Concurrent Infectious Disease |
| 10 | M60.009 | 10 | Concurrent Infectious Disease |
| 10 | M72.6 | 10 | Concurrent Infectious Disease |
| 10 | N10. | 10 | Concurrent Infectious Disease |
| 10 | N12. | 10 | Concurrent Infectious Disease |
| 10 | N15.1 | 10 | Concurrent Infectious Disease |
| 10 | N15.9 | 10 | Concurrent Infectious Disease |
| 10 | N16. | 10 | Concurrent Infectious Disease |
| 10 | N18.6 | 10 | ESRD |
| 10 | N28.84 | 10 | Concurrent Infectious Disease |
| 10 | N28.85 | 10 | Concurrent Infectious Disease |
| 10 | N28.86 | 10 | Concurrent Infectious Disease |
| 10 | N30.00 | 10 | Concurrent Infectious Disease |
| 10 | N30.01 | 10 | Concurrent Infectious Disease |
| 10 | N30.90 | 10 | Concurrent Infectious Disease |
| 10 | N30.91 | 10 | Concurrent Infectious Disease |
| 10 | N34.1 | 10 | Concurrent Infectious Disease |
| 10 | N39.0 | 10 | Concurrent Infectious Disease |
| 10 | Q85.00 | 10 | Concurrent Infectious Disease |
| 10 | Q85.01 | 10 | Concurrent Infectious Disease |
| 10 | Q85.02 | 10 | Concurrent Infectious Disease |
| 10 | Q85.03 | 10 | Concurrent Infectious Disease |
| 10 | Q85.09 | 10 | Concurrent Infectious Disease |
| 10 | R11.11 | 10 | Concurrent Infectious Disease |
| 10 | R75. | 10 | Immunocompromised |
| 10 | R88.0 | 10 | Concurrent Infectious Disease |

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|---|---|---|---|
| 10 | T86.00 | 10 | Immunocompromised |
| 10 | T86.01 | 10 | Immunocompromised |
| 10 | T86.02 | 10 | Immunocompromised |
| 10 | T86.09 | 10 | Immunocompromised |
| 10 | T86.10 | 10 | Immunocompromised |
| 10 | T86.11 | 10 | Immunocompromised |
| 10 | T86.12 | 10 | Immunocompromised |
| 10 | T86.20 | 10 | Immunocompromised |
| 10 | T86.21 | 10 | Immunocompromised |
| 10 | T86.22 | 10 | Immunocompromised |
| 10 | T86.40 | 10 | Immunocompromised |
| 10 | T86.41 | 10 | Immunocompromised |
| 10 | T86.42 | 10 | Immunocompromised |
| 10 | T86.810 | 10 | Immunocompromised |
| 10 | T86.811 | 10 | Immunocompromised |
| 10 | T86.819 | 10 | Immunocompromised |
| 10 | T86.850 | 10 | Immunocompromised |
| 10 | T86.851 | 10 | Immunocompromised |
| 10 | T86.859 | 10 | Immunocompromised |
| 10 | T86.890 | 10 | Immunocompromised |
| 10 | T86.891 | 10 | Immunocompromised |
| 10 | T86.899 | 10 | Immunocompromised |
| 9 | V08. | 10 | Immunocompromised |
| 9 | V42.0 | 10 | Immunocompromised |
| 9 | V42.1 | 10 | Immunocompromised |
| 9 | V42.6 | 10 | Immunocompromised |
| 9 | V42.7 | 10 | Immunocompromised |
| 9 | V42.81 | 10 | Immunocompromised |
| 9 | V42.82 | 10 | Immunocompromised |
| 9 | V42.83 | 10 | Immunocompromised |
| 9 | V42.84 | 10 | Immunocompromised |
| 9 | V42.89 | 10 | Immunocompromised |
| 9 | V42.9 | 10 | Immunocompromised |
| 9 | V45.11 | 10 | Immunocompromised |
| 9 | V45.12 | 10 | Immunocompromised |
| 9 | V56.0 | 10 | ESRD |
| 9 | V56.1 | 10 | ESRD |
| 9 | V56.2 | 10 | ESRD |
| 9 | V56.31 | 10 | ESRD |
| 9 | V56.32 | 10 | ESRD |
| 9 | V56.8 | 10 | ESRD |
| 9 | V58.44 | 10 | ESRD |
| 9 | V87.46 | 10 | Immunocompromised |
| 10 | Z21. | 10 | Immunocompromised |
| 10 | Z48.298 | 10 | Immunocompromised |
| 10 | Z49.01 | 10 | ESRD |
| 10 | Z49.02 | 10 | ESRD |

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| 10 | Z49.31 | 10 | ESRD |
| 10 | Z49.32 | 10 | ESRD |
| 10 | Z91.15 | 10 | ESRD |
| 10 | Z92.25 | 10 | Immunocompromised |
| 10 | Z94.0 | 10 | Immunocompromised |
| 10 | Z94.1 | 10 | Immunocompromised |
| 10 | Z94.2 | 10 | Immunocompromised |
| 10 | Z94.4 | 10 | Immunocompromised |
| 10 | Z94.81 | 10 | Immunocompromised |
| 10 | Z94.82 | 10 | Immunocompromised |
| 10 | Z94.83 | 10 | Immunocompromised |
| 10 | Z94.84 | 10 | Immunocompromised |
| 10 | Z94.89 | 10 | Immunocompromised |
| 10 | Z94.9 | 10 | Immunocompromised |
| 10 | Z99.2 | 10 | ESRD |

| Medications | Exclusion Reason | Prescribed Time Window |
|---|---|---|
| Albuterol/ipratropium | Chronic Lung Disease | Past 2 years |
| Budesonide/formoterol fumarate | Chronic Lung Disease | Past 2 years |
| Cromolyn Sodium | Chronic Lung Disease | Past 2 years |
| Montelukast | Chronic Lung Disease | Past 2 years |
| Olodaterol/tiotropium | Chronic Lung Disease | Past 2 years |
| Tiotropium | Chronic Lung Disease | Past 2 years |
| Ipratropium bromide | Chronic Lung Disease | Past 2 years |
| Aclidinium bromide | Chronic Lung Disease | Past 2 years |
| Fluticasone/vilanterol | Chronic Lung Disease | Past 2 years |
| Fluticasone/salmeterol | Chronic Lung Disease | Past 2 years |
| Fluticasone/mometasone | Chronic Lung Disease | Past 2 years |
| Mepolizumab | Chronic Lung Disease | Past 2 years |
| Olodaterol/tiotropium | Chronic Lung Disease | Past 2 years |
| Umeclidinium | Chronic Lung Disease | Past 2 years |
| Umeclidinium/vilanterol | Chronic Lung Disease | Past 2 years |
| Zafirlukast | Chronic Lung Disease | Past 2 years |
| Atropine | Chronic Lung Disease | Past 2 years |
| Theophylline | Chronic Lung Disease | Past 2 years |
| Guaifenesin/oxytriphylline | Chronic Lung Disease | Past 2 years |
| Zileuton | Chronic Lung Disease | Past 2 years |
| Acitretin | Immunosuppression | Past 1 year |
| Methoxsalen | Immunosuppression | Past 1 year |
| Tumor Necrosis Factor Blockers | Immunosuppression | Past 1 year |
| Immunological Agents | Immunosuppression | Past 1 year |
| Azathioprine | Immunosuppression | Past 1 year |
| Basiliximab | Immunosuppression | Past 1 year |
| Cyclosporine | Immunosuppression | Past 1 year |
| Infliximab-DYYB | Immunosuppression | Past 1 year |
| Murmonab-CD3 | Immunosuppression | Past 1 year |
| Mycopheolate mofetil | Immunosuppression | Past 1 year |
| Mycophenolic acid | Immunosuppression | Past 1 year |
| Siltuximab | Immunosuppression | Past 1 year |
| Sirolimus | Immunosuppression | Past 1 year |
| Tacrolimus | Immunosuppression | Past 1 year |
| Antineoplastics | Immunosuppression | Past 30 days |
| Bisulfan | Immunosuppression | Past 30 days |
| Carmustine | Immunosuppression | Past 30 days |
| Chlorambucil | Immunosuppression | Past 30 days |
| Cyclophosphamide | Immunosuppression | Past 30 days |
| Ifosfamide | Immunosuppression | Past 30 days |
| Ifosfamide/Mesna | Immunosuppression | Past 30 days |
| Lomustine | Immunosuppression | Past 30 days |
| Mechlorethamie | Immunosuppression | Past 30 days |
| Melphalan | Immunosuppression | Past 30 days |
| Thiotepa | Immunosuppression | Past 30 days |
| Bleomycin | Immunosuppression | Past 30 days |

| | | |
|---|---|---|
| Dactinomycin | Immunosuppression | Past 30 days |
| Daunorubicin | Immunosuppression | Past 30 days |
| Doxorubicin | Immunosuppression | Past 30 days |
| Idarubicin | Immunosuppression | Past 30 days |
| Mitomycin | Immunosuppression | Past 30 days |
| Streptozocin | Immunosuppression | Past 30 days |

# Evaluation of Uncomplicated Acute Respiratory Tract Infections (ARI) Management in Veterans: A National Utilization Review

# Appendix B

Data Collection Form

The patient should have presented to the emergency department or outpatient clinic in this time frame:
10/1/2015 - 3/31/2016 (FY16 Q1&Q2)

| Reviewer Initials | VISN | Station | Date of Outpatient Visit (index date) | Date Case Report Completed | Patient identification number |
|---|---|---|---|---|---|
| ☐☐☐ | ☐☐ | | ____/____/____ (mm/dd/yy) | ____/____/____ (mm/dd/yy) | ☐☐☐☐☐☐ |

**General Criteria**

**1. Evaluate that inclusion criteria are met (all criteria must be met)**

☐ Patient presented from the community to a participating VA emergency department, primary care, urgent care, community-based outreach clinic (CBOC), home-based primary care (HBPC), or other outpatient clinic
[Exclude visits to the following subspecialty clinics: Infectious Diseases, Allergy, Gastroenterology, Rheumatology, Psychiatry, ENT, Dentistry, Cardiology, Pulmonology, Dermatology, Podiatry, Surgery (any), Endocrinology, Sleep Medicine, Pain Medicine, Hospice & Palliative Care, Oncology, Hematology, Nephrology, Transplant, Employee and Occupational Health; DO NOT exclude visits to Geriatrics or Women's Health subspecialty clinics.]

☐ Patient has an outpatient diagnosis of one of the following for the visit

**(Check only one box)** ☐ Single ARI ☐ Mixed ARI

**(Check all that apply)** ☐ Acute Pharyngitis ☐ Acute Rhinosinusitis ☐ Acute Bronchitis ☐ URI-NOS

**2. Evaluate if any exclusion criteria are met (check all that apply)**

☐ EXCLUDE if patient has an ICD-10 diagnosis for an ARI on the index date but the symptoms, assessment, and treatment were not addressed by a provider in the notes associated with the encounter

☐ EXCLUDE if ARI diagnosis coded on the encounter was in relation to a resolved ARI

☐ EXCLUDE if patient was admitted to an inpatient ward directly (**within 1 day after index visit**) as a result of the presentation to the outpatient clinic or emergency department

☐ EXCLUDE if patient had an ARI diagnosis **in the previous 30 days to the index date** (do not exclude if diagnosis based on telephone triage contact or similar within the prior 2 days)

☐ Acute Pharyngitis ☐ Acute Rhinosinusitis ☐ Acute Bronchitis ☐ URI-NOS
☐ Other (e.g. otitis media)

☐ EXCLUDE if patient has a diagnosis of chronic pharyngitis or chronic sinusitis (also exclude if patient has signs or symptoms **for ≥12 weeks**)

☐ EXCLUDE if patient has any of the following co-morbid condition(s) that may increase the risk for serious bacterial infections including: (check all that apply)

☐ Neoplasia ☐ Chronic Lung Disease (e.g., COPD, asthma)
☐ End-stage renal disease ☐ Solid Organ Transplantation
☐ Other Immunocompromised States (including HIV)

☐ EXCLUDE if patient has any other active infectious diseases (**at the time of index visit**) including (do NOT exclude patient if he/she had concurrent HCV, HBV, genital herpes, superficial (cutaneous) fungal infection, or similar infections): (check all that apply)

☐ Pneumonia ☐ Influenza ☐ Urinary Tract Infection ☐ Skin or Skin Structure Infection
☐ Acute Otitis Media ☐ Other

☐ EXCLUDE if patient is on acute or chronic oral antibacterial therapy **at time of index visit** including if a patient is self-prescribing antibiotics (DO NOT EXCLUDE if patient was prescribed by a provider an antibacterial agent ≤2 days ago AND if reason started was for ARI signs/symptoms)

** **Stop here if ANY criteria in item #1 ARE NOT met, or ANY criteria in item #2 ARE met. Submit the case report form.** **

**3. Patient Smoking Status (check only one box)**

☐ Current Smoker ☐ Previous Smoker ☐ Never Smoker ☐ Information not available

**4. Treatment Location (check only one box)** ☐ VAMC ☐ CBOC ☐ HBPC

**5. Treatment Setting (check only one box)**

☐ Primary Care Clinic ☐ Urgent Care Clinic ☐ Emergency Dept ☐ Other Outpatient Clinic

**6. Provider Characteristics (check only one box)**

☐ Staff Physician ☐ Mid-level (ie., PA, NP) ☐ Nurse ☐ Pharmacist ☐ Med Resident/Fellow

☐ Other Trainee (ie., Med Student, Pharmacy Resident) ☐ Cannot determine

**7. Does the patient have any documented antibiotic allergy? (check only one box)**

☐ Yes ☐ No

**7a. If yes to question #7, please specify to which antibiotic class(es) the patient is allergic & the reaction that goes with each in the table below.**

| A | B |
|---|---|
| **Antibiotic Class (Allow for multiple allergies to be selected, select all that apply)** | **Reaction (Allow for only one reaction to be selected for each allergy listed, select the appropriate reaction, "other" if not listed, or "unknown" if the reaction is not specified)** |
| 1. Drop Down – Penicillin, Cephalosporin, Sulfa, Carbapenem, Tetracycline, Fluoroquinolone, Macrolide, Clindamycin, Vancomycin, Linezolid, Daptomycin, Other | Drop Down Menu Options – Urticaria, Rash, Anaphylaxis, SJS, GI Upset, Unknown, Other |

**8. Please indicate the patient's first set of vital signs for the index visit below. (please fill in all information in numerical format in the designated unit only; if information not available, type "N/A")**

☐ Temperature: _____ (˚F) ☐ Blood Pressure: Systolic_____(mmHg)

Diastolic_____ (mmHg)

☐ Heart Rate: _____ (BPM) ☐ Respiratory Rate: _____(RPM)

**9. Was the patient self-treating with any medications prior to presenting for the index visit? (check only one box)**

☐ Yes ☐ No ☐ Not Documented

**10. Does the patient complain of having any of the following symptoms within the past two days?**

| A | B |
|---|---|
| **<u>Patient Symptoms/Subjective Findings</u> (Characteristics) (check all characteristics that apply if the given symptom is present) findings may be documented in patient history or elicited on physical examination** | **<u>Presence/Absence/Documentation</u> (check only one box for each row)** |
| a. Self-reported Fever (temperature is recorded elsewhere) | ☐ Yes ☐ No ☐ Not Documented |
| b. Cough (☐ Productive ☐ Non-productive ☐ Unknown) | ☐ Yes ☐ No ☐ Not Documented |
| c. Congestion | ☐ Yes ☐ No ☐ Not Documented |
| d. Nasal Discharge/Rhinorrhea (☐ Purulent ☐ Discolored ☐ Clear ☐ Unknown) | ☐ Yes ☐ No ☐ Not Documented |
| e. Postnasal drip | ☐ Yes ☐ No ☐ Not Documented |
| f. Facial Pain/Pressure/Fullness | ☐ Yes ☐ No ☐ Not Documented |
| g. Ear Pain/Pressure/Fullness | ☐ Yes ☐ No ☐ Not Documented |
| h. GI Symptoms (☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation) | ☐ Yes ☐ No ☐ Not Documented |
| i. Tonsil Involvement (eg., swollen or enlarged tonsils) | ☐ Yes ☐ No ☐ Not Documented |

| | |
|---|---|
| j. Fatigue (feeling tired, sleeping a lot, etc?) | ☐ Yes ☐ No ☐ Not Documented |
| k. Lymph Node Involvement (eg., swollen glands) | ☐ Yes ☐ No ☐ Not Documented |
| l. Abdominal Pain | ☐ Yes ☐ No ☐ Not Documented |
| m. Sore Throat | ☐ Yes ☐ No ☐ Not Documented |
| n. Headache | ☐ Yes ☐ No ☐ Not Documented |
| o. Hoarseness | ☐ Yes ☐ No ☐ Not Documented |
| p. Dyspnea/shortness of breath | ☐ Yes ☐ No ☐ Not Documented |
| q. Wheezing | ☐ Yes ☐ No ☐ Not Documented |
| r. Sneezing | ☐ Yes ☐ No ☐ Not Documented |
| s. Myalgias (eg., achiness) | ☐ Yes ☐ No ☐ Not Documented |

Depending on patient diagnosis(es) (see question #1), please move on to the questions associated with each patient specific diagnosis as indicated below:

- Acute Pharyngitis – Question #11 through #13; then Question #17 – end
- Acute Rhinosinusitis – Question #14; then Question #17 – end
- Acute Bronchitis – Question #15 – end
- URI-NOS – Question #17 – end

**Note: If a patient has more than one diagnosis, all relevant questions for each diagnosis should be answered**

**Acute Pharyngitis**

**11. Which of the following findings documented on clinical exam? (check only one box for each row)**

| A | B |
|---|---|
| 1. Cough | ☐ Yes ☐ No ☐Not Documented |
| 2. Fever (≥101°F) | ☐ Yes ☐ No ☐Not Documented |
| 3. Tonsillar Exudates | ☐ Yes ☐ No ☐Not Documented |
| 4. Tender lymph nodes in neck (Cervical Nodes) | ☐ Yes ☐ No ☐Not Documented |

**12. Was a Group A *Streptococcus* Rapid Antigen Detection Test (RADT) performed? (check only one box)**

☐ Yes ☐ No

**12a. If yes to question #12, what was the result of the Group A *Streptococcus* Rapid Antigen Detection Test (RADT)? (check only one box)**

☐ Positive ☐ Negative

**12b. If yes to question #12, was the result of the Group A *Streptococcus* Rapid Antigen Detection Test (RADT) available at the time of the clinic visit? (check only one box)**

☐ Yes ☐ No

**13. Was a throat culture performed? (check only one box)**

☐ Yes ☐ No

**13a. If yes to question #13, please indicate below the result of the throat culture.**

| A | B |
|---|---|
| | |

| 1. Result (check only one box) | 2. If positive, what pathogen(s) was isolated? (check all that apply) |
|---|---|
| ☐ Positive<br>☐ Negative | ☐ Group A *Strep (S. pyogenes)*<br>☐ Group C *Strep* or Group G *Strep*<br>☐ *S. pneumoniae*<br>☐ *H. influenza* ☐ *Neisseria* spp. ☐ *Mycobacteria* spp.<br>☐ *Fusobacterium* ☐ Other |

Please skip #14 - #16 and move on to question #17 and answer questions through the end of the tool.

**Acute Rhinosinusitis**

**14. Does the patient meet any of the following criteria for Acute Bacterial Rhinosinusitis? (only check a box in columns C through E, if the box for the same row column "B" is checked "Yes")**

| A | B | C | D | E |
|---|---|---|---|---|
| **Signs/Symptoms** | **Presence/Absence/ Not Documented** | **PROLONGED: Are any of the symptoms below persistent for ≥7 days?** | **SEVERE: Are any of the symptoms below referred to as severe or was the temp ≥102˚F for ≥3 days?** | **WORSENING: Did any of the symptoms below worsen after initial improvement over ≥5 days?** |
| 1. Purulent Nasal Discharge | See Question #10, line "d" | -- | ☐ Yes ☐ No<br>☐ Not documented | ☐ Yes ☐ No<br>☐ Not Documented |
| 2. **Facial** Pain, Pressure, and/or Fullness | See Question #10, line "f" | -- | ☐ Yes ☐ No<br>☐ Not documented | -- |
| 3. Congestion | See Question #10, line "c" | ☐ Yes, ≥7 days<br>☐ No<br>☐ Not Documented | -- | -- |
| 4. Hyposmia/Anosmia | ☐ Yes ☐ No<br>☐ Not Documented | ☐ Yes, ≥7 days<br>☐ No<br>☐ Not Documented | -- | -- |
| 5. **Ear** Pain, Pressure, and/or Fullness | See Question #10, line "g" | ☐ Yes, ≥7 days<br>☐ No<br>☐ Not Documented | -- | -- |
| 6. Headache | See Question #10, line "n" | ☐ Yes, ≥7 days<br>☐ No<br>☐ Not Documented | -- | ☐ Yes ☐ No<br>☐ Not Documented |
| 7. Fever (≥100.4 ˚F) | ☐ Yes ☐ No<br>☐ Not Documented | -- | Temp ≥102˚F<br>☐ Yes ☐ No | New Onset Temp ≥100.4˚F<br>☐ Yes ☐ No<br>☐ Not Documented |
| 8. Cough | See Question #10, line "b" | ☐ Yes, ≥7 days<br>☐ No<br>☐ Not Documented | -- | ☐ Yes ☐ No<br>☐ Not Documented |
| 9. Fatigue | See Question #10, line "j" | ☐ Yes, ≥7 days<br>☐ No<br>☐ Not Documented | -- | -- |

Please skip #15 and #16 and move on to question #17, and answer questions through the end of the tool.

**Acute Bronchitis**

**15. Did the provider document pertussis being of diagnostic concern? (check only one box)**

☐ Yes ☐ No

**15a. If yes to question #15, please indicate the documented basis for suspecting pertussis exposure for this patient. (check only one box)**

☐ Confirmed Pertussis Exposure ☐ Suspected Pertussis Exposure ☐ No mention of exposure
☐ Other

**16. Did the patient have any diagnostic test obtained for pertussis? (check only one box)**

☐ Yes ☐ No

**16a. If yes to question #16, what was the result of the diagnostic test for pertussis? (check only one box)**

☐ Positive ☐ Negative

**16b. If yes to question #16a, please indicate the type of diagnostic pertussis test? (check only one box)**

☐ Culture ☐ PCR ☐ Serology

Please continue on to question #17.

**17. Was an antimicrobial prescribed as a result of the initial contact (≤2 days before and <3 days after the index date)? (check only one box)**

☐ Yes ☐ No

**18. Was an antimicrobial dispensed as a delayed prescription (≥3 days after the index visit) a result of the index visit? (check only one box)**

☐ Yes ☐ No

**18a. If yes to question #18, is language present in the note indicating the intention of prescribing a delayed antibiotic? (check only one box)**

☐ Yes ☐ No

**18b. If yes to question #18, what was the time frame for the filling of the antimicrobial prescribed? (check only one box)**

☐ Filled 3-5 days after index visit ☐ Filled ≥6 days after index visit ☐ Not Filled

**19. If yes to questions #17 and/or #18a, please fill in the table below for each antimicrobial that was prescribed as a result of the index visit.**

| A | B | C | D |
|---|---|---|---|
| **Antimicrobial Name (Allow for multiple antibiotics to be selected; select all antibiotics that were prescribed as a result of the index visit; if "Other" is selected, please provide antibiotic name)** | **Duration (# days' supply; provide for each antibiotic prescribed)** | **Date Filled (MM/DD/YY; provide for each antibiotic prescribed)** | **Source of Antibiotic Filled** |
| 1. Drop Down – Amox-Clav, Amoxicillin, Azithromycin, Cefaclor, Cefadroxil, Cefdinir, Cefditoren, Cefixime, Cefpodoxime, Cefprozil, Ceftibuten, Cefuroxime, Cephalexin, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Levofloxacin, | _____ ☐ Not Documented | _____ ☐ Not Documented | ☐ VA Pharmacy ☐ VA Clinic Stock ☐ Outside Pharmacy ☐ Other |

| | | | |
|---|---|---|---|
| Linezolid, Metronidazole, Minocycline, Moxifloxacin, Penicillin, Tedizolid, Telithromycin, Tetracycline, TMP/SMX, Antibiotic prescribed but not specified, Other _____ | | | ☐ Unknown |

**20. Was any symptomatic therapy prescribed or recommended for the patient as a result of the index visit (≤2 days before and <3 days after the index date)? (check only one box)**

☐ Yes ☐ No

**20a. If yes to question #20, please indicate below any symptomatic treatment recommended or prescribed as a result of the visit on the index date (≤2 days before and <3 days after the index date) if applicable.**

| A | B | C |
|---|---|---|
| **Treatment Name (Allow for multiple therapies to be selected; select all therapies that were recommended/prescribed as a result of the index visit; if "Other" is selected, please provide name of therapy)** | **Recommendation or Prescription? (select only one box per therapy)** | **Date Filled (if prescribed) (MM/DD/YY)** |
| 1. Medication Class Drop Down – Sedating Antihistamine, Non-sedating Antihistamine, Analgesic, Intranasal Steroid, Cough Suppressant, Steroid Inhaler, Beta-agonist Inhaler, Lozenges, Decongestant, Expectorant, Medication class prescribed/recommended but not specified, Other _____ | ☐ Recommendation<br>☐ Prescription<br>☐ Not Documented | _____<br>☐ Not Documented |

**21. Does the patient have a positive *C. difficile* toxin assay up to 30 days before the index date? (check only one box)**

☐ Yes ☐ No

**22. Does the patient have a positive *C. difficile* toxin assay up to 30 days after the index date? (check only one box)**

☐ Yes ☐ No

**23. Did the patient have a return urgent care/ED/primary care visit within 30 days of the index visit related to the ARI complaint of the index visit? (check only one box) [Do not include other previously scheduled appointments (eg., orthopedic clinic, dermatology clinic, etc.)**

☐ Yes ☐ No

**23a. If yes to question #23, which of the following conditions below best describe the reason for the return urgent care/ED/primary care visit? (check only one box)**

☐ Patient has unresolved/worsening ARI symptoms
☐ Patient has an ARI complication such as pneumonia or rheumatic fever
☐ Other

**23b. If yes to question #23, did the patient have an antimicrobial prescribed as a result of the return visit (≤2 days before and <3 days after the return visit date)? (check only one box)**

☐ Yes ☐ No

**23c. If yes to question 23b, please fill in the table below (≤2 days before and <3 days after the return date). (If data is not available, please select "N/A")**

| A | B | C | D |
|---|---|---|---|
| **Antimicrobial Name (Allow for multiple antibiotics to be selected; select all antibiotics that were prescribed as a result of the return visit; if "Other" is selected, please provide antibiotic name)** | **Duration (# days' supply; provide for each antibiotic prescribed)** | **Date Filled (MM/DD/YY; provide for each antibiotic prescribed)** | **Source of Antibiotic Filled** |

| | | | |
|---|---|---|---|
| 1. Drop Down – Amox-Clav, Amoxicillin, Azithromycin, Cefaclor, Cefadroxil, Cefdinir, Cefditoren, Cefixime, Cefpodoxime, Cefprozil, Ceftibuten, Cefuroxime, Cephalexin, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Levofloxacin, Linezolid, Metronidazole, Minocycline, Moxifloxacin, Penicillin, Tedizolid, Telithromycin, Tetracycline, TMP/SMX, Antibiotic prescribed but not specified, Other _____ | _____ ☐ Not Documented | _____ ☐ Not Documented | ☐ VA Pharmacy ☐ VA Clinic Stock ☐ Outside Pharmacy ☐ Other ☐ Unknown |

**24. Was there a telephone encounter ≤30 days after the index visit regarding the status of the patients ARI diagnosis?**
☐ Yes ☐ No

Only answer the following questions if the answer to question #24 was "Yes".

**24a. Who documented the telephone encounter?**
☐ Physician ☐ PA/NP ☐ Pharmacist ☐ Nurse ☐ Medical Assistant
☐ Other Trainee (ie., Med Student, Pharmacy Resident) ☐ Cannot determine
☐ Medical Resident/Fellow

**24b. Which party initiated the telephone encounter (ie., did the patient call the health care professional or did the health care professional call the patient)?**
☐ Health Care Professional ☐ Patient ☐ Not Documented

**24c. Was the patient's condition (e.g., ARI symptoms) documented during the telephone encounter?**
☐ Yes ☐ No

**24d. Was the patient's condition (e.g., ARI symptoms) resolving, worsening, or unchanged?**
☐ Resolving ☐ Worsening ☐ Unchanged ☐ Not Documented

**24e. Did the health care professional ask the patient to come in for a clinic visit?**
☐ Yes ☐ No

**24f. Was a medication (either antibiotic or symptomatic therapy) initiated as a result of the telephone encounter?**
☐ Yes ☐ No

**24g. If an antibiotic or symptomatic therapy was recommended/prescribed, please provide details below.**

| A | B | C | D | E |
|---|---|---|---|---|
| **Antimicrobial/Treatment Name (Allow for multiple antibiotics/treatments to be selected; select all antibiotics/treatments that were recommended/prescribed as a result of the telephone call; if "Other" is selected, please provide antibiotic/treatment name)** | **Recommendation or Prescription? (select only one box per therapy)** | **Duration (# days' supply; provide for each <u>antibiotic</u> prescribed)** | **Date Filled (MM/DD/YY; provide for each)** | **Source of Antibiotic Filled** |
| 1. Drop Down – Amox-Clav, Amoxicillin, Azithromycin, Cefaclor, Cefadroxil, Cefdinir, Cefditoren, Cefixime, Cefpodoxime, Cefprozil, Ceftibuten, Cefuroxime, Cephalexin, Ciprofloxacin, Clarithromycin, Clindamycin, Dicloxacillin, Doxycycline, Erythromycin, Levofloxacin, Linezolid, Metronidazole, Minocycline, Moxifloxacin, Penicillin, Tedizolid, Telithromycin, Tetracycline, | N/A | _____ ☐ Not Documented | _____ ☐ Not Documented | ☐ VA Pharmacy ☐ VA Clinic Stock ☐ Outside Pharmacy ☐ Other ☐ Unknown |

| | | | | |
|---|---|---|---|---|
| TMP/SMX, Antibiotic prescribed but not specified, Other _____ | | | | |
| 1. Medication Class Drop Down – Sedating Antihistamine, Non-sedating Antihistamine, Analgesic, Intranasal Steroid, Cough Suppressant, Steroid Inhaler, Beta-agonist Inhaler, Lozenges, Decongestant, Expectorant, Medication class prescribed/recommended but not specified, Other _____ | ☐ Recommendation<br>☐ Prescription<br>☐ Not Documented | N/A | _____<br>☐ Not Documented | N/A |

1. with an "x" at the end of the number such as D70.x means that all numbers starting with D70 will be included with that diagnostic criteria (ie., D70.2, D70.18)
    - **a.** Associated diagnosis codes are provided to aid in identifying if patient meets criteria, but should not be used as only method for identification. **Please review chart for any un-coded but documented disease states as well.**

| Information Field | Instructions for Field Collection |
|---|---|
| Reviewer Initials | Enter the first, middle, and last initials of the individual completing the data collection form |

| | |
|---|---|
| VISN | Enter the VISN number for the facility where the outpatient ARI visit occurred |
| Station | Enter the station of the facility where the ARI visit occurred |
| Date of Outpatient Visit | Enter the date of the outpatient visit based on the clinic/ED visit note using MM/DD/YY |
| Date Case Report Completed | Enter the date data collection was completed using the MM/DD/YY format |
| Patient Identification # | Enter assigned patient identification number |

| **Data Point** | **Data to be collected** | **Data Source & Details**<br><br>**(NOTE: There are several ways to access identical information in CPRS; reviewers can use this information as a guide but are free to use alternate tools in the system to arrive at the requested data points.)** |
|---|---|---|
| 1 | **Verify inclusion criteria are met (all criteria must be met)** | |
| | Patient presented to participating VA outpatient facility from the community | CPRS -> Notes -> Outpatient/ED Visit Note<br><br>Presentation from the community is defined as any patient who presents excluding facility or ED transfers for admission and nursing home, CLC patients, and patients from rehab facilities. Examples of patients from the community include patients presenting from private residence, assisted living facilities, foster homes, domiciliary housing, and patients who may be homeless or living in shelters or hotels.<br><br>Patients also must be presenting as outpatients to the emergency department, primary care, urgent care, community-based outreach clinic, home-based primary care, or other outpatient clinic.<br><br>Exclude visits to the following subspecialty clinics: Infectious Diseases, Allergy, Gastroenterology, Rheumatology, Psychiatry, ENT, Dentistry, Cardiology, Pulmonology, Dermatology, Podiatry, Surgery (any), Endocrinology, Sleep Medicine, Pain Medicine, Hospice & Palliative Care, Oncology, Hematology, Nephrology, Transplant, Employee and Occupational Health; DO NOT exclude visits to Geriatrics or Women's Health subspecialty clinics. |
| | Patient has ARI diagnosis for the index visit | CPRS -> Notes -> Outpatient/ED Visit Note -> Encounter Information<br><br>Patient must have a visit diagnosis consistent with one or more of the following ARI conditions: Acute Pharyngitis, Acute Bacterial Rhinosinusitis, Acute Bronchitis, or Upper Respiratory Infection – Not Otherwise Specified (URI-NOS). Ensure patients actually have an ARI to make sure that an ARI diagnosis was not coded (using ICD-10 codes) |

| | | |
|---|---|---|
| | | erroneously. Of note, we will be excluding any patients with otitis media in addition to another ARI diagnosis.<br><br>Associated ICD-10 codes include:<br>Acute Pharyngitis: J02.9<br>Acute Rhinosinusitis: J01.0-J01.9<br>Acute Bronchitis: J20.9<br>URI-NOS: J04.0, J06.0, J06.9<br><br>ICD-10 codes are provided to aid in identifying if patient meets criteria, but should not be used as the only method for identification. Un-coded but documented disease states of interest by a medical professional (i.e., licensed independent practitioners) count as well. Please avoid using notes authored by physical therapy or occupational therapy. If patients have multiple diagnoses either coded for or mentioned in note, document as mixed ARI choosing the specific ARIs that the patient has. Please use the following logic when determining patient diagnosis:<br><br>If there is no specific diagnosis mentioned or it is vague within the provider notes, then use the coded diagnosis from the encounter information.<br><br><u>Potential Special Circumstances/Issues:</u><br>1) The coded ARI is different than the documented ARI – The documented ARI trumps the coded ARI – do not select mixed ARI if only one is specified in the documentation even if a different ARI is coded<br>2) There is documentation supporting more than one ARI but only one is coded – Select 'mixed ARI' and specify which diagnoses are documented<br>3) Documentation does not specify one ARI or the other – if symptoms documented are consistent with one ARI over another (i.e., the patient only has a cough and no sore throat or runny nose) then select the most appropriate ARI. Otherwise, select the URI-NOS if the specific ARI is not absolutely clear.<br><br>If the patient has multiple visits for an ARI diagnosis in the MUE timeframe, use only the first visit date |
| *****STOP if ANY inclusion criteria are NOT met. Submit case report form***** | | |
| 2 | **Confirm no exclusion criteria are met** | |
| | ARI diagnosis coded on index date but symptoms, assessment, and treatment of an ARI were not assessed by a provider in the notes | If an ARI was coded but not addressed at the visit on the index date, exclude the patient from the evaluation.<br><br>Do not exclude the patient if only signs/symptoms are noted, if a different ARI is noted than what is coded, or if there is laboratory evidence of a possible ARI (e.g., rapid antigen strep test or throat culture). |

| | | |
|---|---|---|
| | associated with the encounter | |
| | ARI diagnosis coded on the encounter was in relation to a resolved or resolving ARI | If an ARI diagnosis was coded and it was referencing a resolved or resolving condition, exclude the patient from the evaluation as this is not a new presentation. |
| | Admission to inpatient ward directly as a result of the index visit | CPRS -> Notes -> H&P Note<br><br>Verify no hospital admission within 24 hours after index visit or mention of admission to hospital ward in index visit note |
| | Any ARI diagnosis in the 30 days prior to index visit | CPRS -> Problems -> Both active and inactive **AND** CPRS -> Notes<br><br>Ensure no ARI diagnosis consistent with Acute Pharyngitis, Acute Bacterial Rhinosinusitis, Acute Bronchitis, Upper Respiratory Infection – Not Otherwise Specified (URI-NOS), or Other (e.g. acute otitis media) in the 30 days prior to the index visit. This includes visits to non-VA facilities which may be stated in the any of the notes including the index visit note in addition to any notes in the previous 30 days. However, DO NOT exclude patients with a ARI diagnosis in the past two days if that diagnosis is based on a telephone triage or similar note (i.e., diagnosis without being seen by a provider)<br><br>Associated ICD-10 codes include:<br>Acute Pharyngitis: J02.9<br>Acute Rhinosinusitis: J01.0-J01.9<br>Acute Bronchitis: J20.9<br>URI-NOS: J04.0, J06.0, J06.9 |
| | Presence of diagnosis for chronic pharyngitis or chronic sinusitis | CPRS -> Problems -> Active<br><br>Ensure no diagnoses related to chronic pharyngitis or chronic sinusitis. Refer to previous notes in the chart as well to get an idea if the ARI diagnosis may be a chronic condition that may be coded incorrectly. Exclude patient is signs/symptoms consistent with pharyngitis or sinusitis for ≥12 weeks. For example, multiple previous notes over the course of several months identifying sinusitis as a problem.<br><br>Associated ICD-10 codes include:<br>Chronic Pharyngitis: J31.2<br>Chronic Sinusitis: J32.0-J32.9 |
| | Presence of any of the co-morbid conditions that may increase the risk for serious bacterial infection | CPRS -> Problems -> Both active and inactive **AND** CPRS -> Notes -> Active Problem Lists & Past Medical History<br><br>Ensure no diagnosis related to any of the following conditions: Neoplasia, Chronic Lung Disease (COPD), End-stage Renal Disease, Solid Organ Transplantation, or Other Immunocompromised States (including HIV). Also, be sure to look at the past medical history in notes in case there was a diagnosis that was not coded or coded incorrectly for the index visit. |

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| | | Goal is to exclude any patient at higher risk for contracting a bacterial infection.<br><br>If excluding a patient due to Neoplasia, ensure the patient was receiving active chemotherapy or radiation therapy, or had metastatic disease at the time of the index visit. Otherwise, do not exclude patient. Examples of patients that should NOT be excluded are: 1) a patient with a non-melanoma skin cancer, or 2) a patient with a history of prior colon cancer now in remission for 5 years after surgical colonic resection.<br><br>Other immunocompromised states include but may not be limited to: use of rheumatologic agents, anti-rejection medications, asplenia, chronic steroid use equivalent to ≥20mg prednisone for ≥2 weeks, and ANC <1500.<br>DE810 – Antipsoriatics, Systemic<br>GA400 – Tumor Necrosis Factor Blocker<br>IM000 – Immunological Agents<br>IM600 – Immune Suppressants<br><br>Associated ICD-10 codes include:<br>Neoplasia: C00.0-C96.x, D00.1-D48.9, K31.7, K63.5, Q85.0x<br>Chronic Lung Disease (COPD, Asthma): J40.x-J45.998, J47.x, J67.x<br>End-stage Renal Disease: N18.6, R88.0, Z49.01, Z49.02, Z49.31, Z49.32, Z91.15, Z99.2<br>Transplantation: T86.10-T86.899, Z94.x, T86.0x<br>Other Immunocompromised State: D70.x, D80.8, D83.1, Z92.25, R75, Z21 |
| | Presence of any other active infectious diseases diagnosis on index date | CPRS -> Problems -> Both active and inactive **AND** CPRS -> Notes -> Active Problem Lists & Past Medical History<br><br>Ensure no other acute infectious diseases diagnosis is present including but not limited to Pneumonia, Influenza, Urinary Tract Infections, and Skin and Skin Structure Infections. Other infectious diseases included in the exclusion can be viral, bacterial, fungal, and/or parasitic diagnoses including but not limited to tuberculosis, eye infections, ear infections, and osteomyelitis. Provider must mention that patient may have a concurrent infection at time of visit for the patient to be excluded for that reason. If a patient is on antimicrobial(s) either acutely or chronically, check both coded and un-coded problem lists and past medical histories to see if the patient has a concurrent infection.<br><br>Do <u>NOT</u> exclude patient if the patient had concurrent HCV, HBV, genital herpes, superficial (cutaneous) fungal infection, or similar infections.<br><br>Associated ICD-10 codes include: A00.0-99.0, B00.0-99.9, D86.9, G02, G14, H32, I32, I39, J02.0, J003.00, J17, K90.81, L08.1, L44.4, L94.6, M02.30, M35.2, M60.009, N34.1, R11.11<br><br>Please check the appropriate diagnosis or fill in specific diagnosis if "Other" |
| | Presence of any current acute or chronic | CPRS -> Meds -> Active Outpatient Meds both VA **AND** non-VA meds |

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| | antimicrobial therapy at time of index visit | Ensure that the patient is not currently being treated either acutely or chronically with any oral antibacterial therapy whether an active infectious diagnosis is identified or not. Exclude patients that may be taking self-prescribed antibiotics (e.g., using stockpiled antibiotics at home).<br><br>Do NOT exclude if a patient was prescribed by a provider an antibacterial agent ≤2 days prior to index visit AND if reason started was for ARI signs/symptoms (look for previous nursing note or telephone intervention note). |
| *****STOP if ANY exclusion criteria are met. Submit case report form***** | | |
| 3 | Document patient smoking status | CPRS -> Notes -> Clinic/ED Note -> Social History<br><br>Current Smoker: Any patient with a positive smoking history within the past 1 month<br>Previous Smoker: Any patient with a smoking history, but who has quit/stopped smoking >1 month ago<br>Never Smoker: Any patient with no smoking history<br>Information Not Available: Any patient with no smoking history recorded in the medical record.<br><br>Note: This only pertains to smoking tobacco or use of electronic alternative, and not for example chewing tobacco.<br><br>Please check only one box. |
| 4 | Treatment Location | CPRS -> Notes -> Clinic/ED Note -> Determine location based on specific clinic or ED<br><br>Indicate whether the patient presented to Veteran's Affairs Medical Center (VAMC), Community-Based Outreach Clinic (CBOC), or Home-Based Primary Care (HBPC).<br><br>If a patient presents to an outpatient clinic (OPC) that is not considered a CBOC or HBPC, select "VAMC". |
| 5 | Treatment Setting | Determine whether the patient was seen in a primary care clinic, urgent care clinic, other outpatient clinic, or emergency department. For HBPC, select "Primary Care".<br><br>Telephone encounters do not count as the patient is not physically presenting to the facility or the provider is not physically seeing the patient. |
| 6 | Provider Characteristics | CPRS -> Notes -> Clinic/ED Note -> Author<br><br>Determine who the primary provider was for the visit as identified as the primary author on the index visit note. The primary author should be found at the top, left-hand side of the note in the heading. Co-signers and additional signers **do not count** as authors for the purposes of the evaluation. An exception to this is if the nurse documents the encounter with the physician's plan in the note. If this occurs, the primary provider for the visit would be the physician. |

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| 7 | Documented antibiotic allergy present | CPRS -> Cover Sheet -> Allergies/Adverse Reactions **OR** CPRS -> Notes -> Clinic/ED Note<br><br>Please indicate if the patient has an antibiotic allergy listed in CPRS or in the clinic or ED note. Please include even if the allergy appears to be a side effect (ie., GI upset). |
| 7a | Documented antibiotic allergy details | CPRS -> Cover Sheet -> Allergies/Adverse Reactions<br><br>**Only complete this item if you answered "yes" to the patient having an antibiotic allergy**<br><br>Please indicate specific antibiotic class and reaction to each from the respective menus. If the patient's reaction is not present in the drop down menu, select "other". If the patient's reaction is not documented or unknown, select "unknown". |
| 8 | Documentation of vital signs | CPRS -> Notes -> Clinic/ED visit note<br><br>Please document the value for each vital sign provided under item #8 in the following units: Temperature – ˚F; Heart Rate – beats per minute; Blood Pressure – mmHg/mmHg; Respiratory Rate – respirations per minute. If more than one set of vital signs taken for the index visit, record the first set obtained for that visit.<br><br>Note – the values entered for each item must be within the following ranges (do not include numbers or symbols in these fields except for a decimal where appropriate):<br>• Temperature (˚F): 96-106 (with up to 1 decimal place)<br>• Heart Rate (BPM): 30-180<br>• Systolic BP (mmHg): 70-200<br>• Diastolic BP (mmHg): 40-130<br>• Respiratory Rate (RPM): 6-40 |
| 9 | Documentation of prior self-treatment | CPRS -> Notes -> Clinic/ED visit note<br><br>Please check "yes", "no", or "not documented regarding whether the patient was self-treating with any medications prior to presenting at the index visit. Only medications and no herbal supplements should be considered. |
| 10 | Documentation of signs/symptoms and/or chief complaints | CPRS -> Notes -> Clinic/ED visit note<br><br>Please indicate any and all signs/symptoms the patient is exhibiting within the past 2 days by checking the boxes "Yes", "No", or "Not Documented for each item. Findings may be documented in patient history or elicited on physical examination.<br><br>Clarifications:<br>• Chills alone should **not** constitute a positive finding of Fever<br>• Sinus pain/pressure fullness should constitute a positive finding of Facial Pain/Pressure/Fullness. |

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| | | • If drainage is not defined further, Nasal Discharge should be the finding recorded.<br>• Dysphagia does **not** constitute sore throat.<br>• If symptoms pertaining to HEENT in ROS are documented as "WNL", "No" should be marked for the HEENT symptoms, unless specific symptoms are noted elsewhere in the chart. |
| ***Please move on to the corresponding item(s) associated with the patient's specific ARI diagnosis.** For Acute Pharyngitis, move to item #11. For Acute Bacterial Rhinosinusitis, move on to item #14. For Acute Bronchitis, move on to item #15. For URI-NOS, move on to item #17*** | | |
| 11 | Document findings on clinical exam | ***Only answer this item if the patient's ARI diagnosis is Acute Pharyngitis***<br><br>CPRS -> Notes -> Clinic/ED visit note ->HPI, Vital Signs, Review of Systems, Physical Exam<br><br>Please note whether the patient fulfills any of the criteria noted in the table. If a criterion is not documented, please select "Not Documented". Only select "No" if there is documentation identifying that the patient does not meet the criterion. |
| 12 | Group A *Streptococcus* Rapid Antigen Detection Test (RADT) | ***Only answer this item if the patient's ARI diagnosis is Acute Pharyngitis***<br><br>CPRS -> Labs -> Select test by date -> Search for lab test<br><br>Terms you may want to try to find this test includes: "rapid", "Group A Strep", and "RADT".<br><br>Please indicate whether an RADT was **PERFORMED.** An RADT was performed if there is a result (positive or negative). |
| 12a | Group A *Streptococcus* Rapid Antigen Detection Test (RADT) result | ***Only answer this item if the patient's ARI diagnosis is Acute Pharyngitis***<br><br>CPRS -> Labs -> Select test by date -> Search for lab test<br><br>Please indicate the result of the RADT. If no RADT was performed, move on, and do NOT answer this question. If a non-VA RADT was done in lieu of a VA test and is documented in the visit note, include the results of the non-VA RADT in the data collection form. |
| 12b | Was the RADT result available during the clinic visit? | ***Only answer this item if the patient's ARI diagnosis is Acute Pharyngitis***<br><br>Please indicate whether the RADT result was available at the clinic visit. This information may be found as evidenced by the clinic note referring to the RADT result (not including any addendums that could have been added after the visit) or by comparing the time the note was completed to the time the RADT was resulted. |
| 13 | Throat Culture performed | ***Only answer this item if the patient's ARI diagnosis is Acute Pharyngitis***<br><br>CPRS -> Labs -> Microbiology -> |

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| | | Please indicate whether a throat culture was **PERFORMED**. A throat culture was performed if there is a result (positive or negative). |
| 13a | Throat Culture details | ***Only answer this item if the patient's ARI diagnosis is Acute Pharyngitis***<br><br>CPRS -> Labs -> Microbiology-><br><br>Please indicate the result of the throat culture and the organism that was identified. If the organism that was identified is something other than what is listed, please select other. Note: Group C *Strep* or Group G *Strep* is one choice. Examples of Group C and G *Strep* can include *S. dysgalactiae, S. equi, S. zooepidemicus, S. canis,* and *S. equisimlis*. Group A *Strep* includes *S. pyogenes*.<br><br>If no throat culture was performed, move on and do NOT answer this question. |
| ***If the patient has a diagnosis of Acute Pharyngitis and you answered items #11-13, please move on to item #17 skipping the items in between*** | | |
| 14 | Document criteria fulfilled by patient | ***Only answer this item if the patient's ARI diagnosis is Acute Bacterial Rhinosinusitis***<br><br>CPRS -> Notes -> Clinic/ED visit note -> HPI, Vital Signs, Review of Systems, Physical Exam<br><br>PROLONGED Criterion: A patient must have at least 1 of the signs/symptoms listed for greater than ≥7 days without improvement over that time frame. Other words okay to describe greater than 7 days include words like "many" and "a lot of".<br><br>SEVERE Criterion: At least 1 of the signs/symptoms listed must be described as "severe" by the patient or provider as documented in the note. Other words okay to describe ≥3 days include words like "few" and "several". The word "couple" should not fulfill this criterion.<br><br>WORSENING Criterion: At least 1 of the signs/symptoms listed needs to persist for 3-4 days after initial improvement of symptoms of an infection lasting at least 5 days (see visual below). Other acceptable words to describe 3-4 days include words like "few" and "several". The word "couple" should not fulfill this criterion. If the provider mentions the term "double-sickening" in the note, that will also fulfill this criterion. See Figure 1 at the end of the document.<br><br>Instructions for filling out the table: First, determine which signs and symptoms were present and for how long in column "A (whether any of the symptoms documented were present for ≥10 days.) Then select the appropriate box in column "B" for each symptom. Next, look at each of the remaining column separately and determine if any of the symptoms described match the criteria noted at the heading of each column or in this document. Then, select the appropriate boxes in each column accordingly. |

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| | | If documentation for timeframe of signs/symptoms is in days then longevity criteria should be applied as is. If documentation for timeframe is stated as "greater than a week", then that will be sufficient to fulfill ANY longevity criterion. Additionally, if inexact quantitative or qualitative measurements are used for time or severity, use clinical judgement to ensure the intent of the criteria is met. |
| *****If the patient has a diagnosis of Acute Bacterial Rhinosinusitis and you answered item #14, please move on to item #17 skipping the items in between***** | | |
| 15 | Documentation of suspected pertussis (pertussis of diagnostic concern) | *****Only answer this item if the patient's ARI diagnosis is Acute Bronchitis*****<br><br>CPRS -> Labs -> Select the appropriate timeframe -> Search for lab test **OR**<br>CPRS -> Notes -> Clinic/ED visit note -> HPI/Assessment/Plan<br><br>Please indicate whether there is any documentation of suspected pertussis including patient history pertinent for exposure to pertussis or language identifying pertussis as a possible diagnostic concern (this can include ordering a pertussis diagnostic lab test) |
| 15a | Documentation of pertussis exposure suspicion | *****Only answer this item if the patient's ARI diagnosis is Acute Bronchitis*****<br><br>CPRS -> Labs -> Select the appropriate timeframe -> Search for lab test **OR**<br>CPRS -> Notes -> Clinic/ED visit note -> HPI/Assessment/Plan<br><br>Please indicate in which category the suspicion fits:<br>• Confirmed Pertussis Exposure – Only select this box if the exposure was to someone who was known to have pertussis. Do not include if exposure was to someone who was only being treated with antibiotics without actually testing positive for pertussis. Patient must know that the exposure was to someone with known diagnosed pertussis.<br>• Suspected Pertussis Exposure – Select this box if there was a possible exposure including if the exposure was to someone being treated without confirmed lab tests or exposure was to someone with symptoms consistent with pertussis.<br>• No mention of exposure – Select this box if there is no mention of pertussis exposure in the index visit note<br>• Other – select this box if there is documentation that does not meet the other explanations<br><br>If there was no documentation of pertussis being of diagnostic concern (answering "No" to #15), move on and do NOT answer this question |
| 16 | Diagnostic test for pertussis obtained | *****Only answer this item if the patient's ARI diagnosis is Acute Bronchitis*****<br><br>CPRS -> Labs -> selected test by date -> Search for lab test<br><br>Please indicate whether a diagnostic lab test for pertussis was **ORDERED**. Lab tests for pertussis include nasopharyngeal swab/aspirate PCR/culture and/or serology. |
| 16a | Diagnostic test for pertussis result | *****Only answer this item if the patient's ARI diagnosis is Acute Bronchitis***** |

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| | | CPRS -> Labs -> Selected test by date -> Search for lab test<br><br>Please indicate the result of the diagnostic lab test for pertussis. Lab tests for pertussis include nasopharyngeal swab/aspirate PCR/culture and/or serology. |
| 16b | Type of diagnostic pertussis test if positive | ***Only answer this item if the patient's ARI diagnosis is Acute Bronchitis***<br><br>CPRS -> Labs -> Selected test by date -> Search for lab test<br><br>Please indicate the type of diagnostic test pertussis (Culture, Serology, PCR) if the result was positive. |
| ***Please continue on to item #17*** | | |
| 17 | Antimicrobial prescribed | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range ≤2 days before and <3 days after the index visit **AND** CPRS -> Notes -> Treatment Plan<br><br>Please indicate whether the patient was prescribed an antibiotic as a result of the initial contact (≤2 days before and <3 days after the index date) either in the medication history in CRPS or by indication in the plan in the index visit note. Please also include the source of antibiotic dispensed as well. |
| 18 | **DELAYED** antimicrobial prescribed | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range 3 days after the index visit **AND** CPRS -> Notes -> Treatment Plan<br><br>In order for an antimicrobial prescribed to be considered a delayed prescription for this question, the antibiotic must have been dispensed ≥3 days after the index date.<br><br><u>If the prescription was delayed, continue to questions 18 and 18b.</u> |
| 18a | **DELAYED** antimicrobial language present | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range 3 days after the index visit **AND** CPRS -> Notes -> Treatment Plan<br><br>Please answer this question if, the answer to #18 was "yes". Use your judgement and the language provided in the clinic note to determine if the prescriber's intention was to prescribe a **DELAYED** antibiotic to be filled after the index visit. If the patient is provided a prescription for an antibiotic or the actual antibiotic, it should not be considered a **DELAYED** antibiotic regardless of documented directions from the prescriber. |
| 18b | **DELAYED** antibiotic filling time frame | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range 3 days after the index visit |

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| | | Please select the appropriate box for the time frame in which the patient filled the **DELAYED** antibiotic prescription. If the patient did not end up filling the prescription, select the appropriate box. |
| 19 | Documentation of antimicrobial prescription | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range ≤2 days before and <3 days after the index visit **AND** CPRS -> Notes -> Treatment Plan<br><br>If an antimicrobial was prescribed, please indicate the following:<br>• Antibiotic Name: Select from the drop down menu. If the antibiotic is not present, select other and fill in the antibiotic that was prescribed<br>• Duration: Determine duration either from the quantity and SIG of the prescription or by documentation in the index visit note<br>• Date filled: Use MM/DD/YY format<br><br>**Note: If more than one antimicrobial was ordered, input each antimicrobial separately.**<br><br>**Note: For duration and date filled, below are examples for when to select "Not documented"<br>• A clinician writing a prescription for patient to fill at an outside pharmacy but clinician does not document duration/date filled<br>• An antimicrobial is pulled out of the medicine cabinet but quantity was not documented<br><br>If no antimicrobial was prescribed, move on and do NOT answer this question. |
| 20 | Symptomatic treatment recommended or prescribed | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range ≤2 days before and <3 days after the index visit **AND** CPRS -> Notes -> Clinic/ED visit note<br><br>Determine if symptomatic treatment was prescribed or recommended during the timeframe through either the medication history in CPRS or by indication in the treatment plan. Only include symptomatic treatment that the patient was self-treating with if there is documentation [either in current note or previous note (ie., phone call)] that it was recommended by a VA provider. |
| 20a | Documentation specifics of symptomatic treatment recommended or prescribed | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range ≤2 days before and <3 days after the index visit **AND** CPRS -> Notes -> Clinic/ED visit note<br><br>If a medication was prescribed or recommended, select the specific medication, whether it was prescribed or recommended, and the date filled if the medication was prescribed in MM/DD/YY format. If the name of the therapy recommended or prescribed is not in listed in the drop down menu, select "other" and fill in the name. Fill in the name of the medication class for each medication prescribed or recommended.<br><br>Clarifications:<br>• If symptomatic therapy is identified by a brand name, please select the appropriate class for the active ingredient in that product. |

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| | | • If a combination product is identified, select each class for each active ingredient as if each were a separate medication.<br><br>If no symptomatic therapy was prescribed or recommended during this timeframe, move on and do NOT answer this question. Please list each medication separately. |
| 21 | Documentation of positive *C. difficile* toxin assay 30 days **BEFORE** index visit | CPRS -> Labs -> Worksheet -> Search for *C. difficile* toxin assay and select appropriate assay -> Date Range -> Type in 30 days **BEFORE** the index visit -> Identify if labs are obtained and the result<br><br>Identify whether the patient had an assay obtained for each timeframe before and after the index date. If the test was obtained during either or both timeframes, select the appropriate box corresponding to the result. Non-VA labs count for this as well if documented and the timing of the labs can be determined. |
| 22 | Documentation of positive *C. difficile* toxin assay 30 days **AFTER** index visit | CPRS -> Labs -> Worksheet -> Search for *C. difficile* toxin assay and select appropriate assay -> Date Range -> Type in 30 days **AFTER** the index visit -> Identify if labs are obtained and the result<br><br>Identify whether the patient had an assay obtained for each timeframe before and after the index date. If the test was obtained during either or both timeframes, select the appropriate box corresponding to the result. Non-VA labs count for this as well if documented and the timing of the labs can be determined. |
| 23 | Presence of outpatient/ED return visit within 30 days | CPRS -> Notes -> View notes for possible encounters within 30 days<br><br>Look within CPRS to find if the patient returned to urgent care, ED, or primary care within 30 days of the index visit related to the ARI complaint of the index visit. Do not include other previously scheduled appointments (eg., orthopedic clinic, dermatology clinic, etc.). If the patient has worsening symptoms leading to a lower respiratory tract infection including pneumonia, this will count as ARI-related. |
| 23a | Documentation of reason for outpatient/ED return visit with 30 days | CPRS -> Notes -> View notes for possible encounters within 30 days<br><br>View the note for the return visit within 30 days and determine the chief complaint or reason for the visit. Select the option that most closely reflects the reason for the visit as it related to the index visit. If none of the prepopulated reasons apply, select other.<br><br>If the patient did not have a return visit within 30 days of the index visit, do NOT answer this question. |
| 23b | Presence of antibiotic prescription as a result of the 30-day return visit | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range ≤2 days before and <3 days after the 30-day return visit **AND** CPRS -> Notes -> Treatment Plan<br><br>Please indicate whether the patient was prescribed an antibiotic as a result of the 30-day return visit (≤2 days before and <3 days after the index date) either in the medication history in CRPS or by indication in the plan in the 30-day return visit. If the patient did not have a 30-day return visit, do NOT answer this question. |

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| 23c | Documentation of antimicrobial prescribed as a result of the 30-day return visit | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the date range ≤2 days before and <3 days after the 30-day return visit **AND** CPRS -> Notes -> Treatment Plan<br><br>If an antimicrobial was prescribed, please indicate the following:<br>• Antibiotic Name: Select from the drop down menu. If the antibiotic is not present, select other and fill in the antibiotic that was prescribed<br>• Duration: Determine duration either from the quantity and SIG of the prescription or by documentation in the index visit note<br>• Date filled: Use MM/DD/YY format<br><br>**Note: If more than one antimicrobial was ordered, input each antimicrobial separately.**<br><br>If no antimicrobial was prescribed, do NOT answer this question. |
| 24 | Documentation of telephone encounter ≤30 days after index visit | CPRS -> Notes -> Telephone Encounter Note ≤30 days after index visit<br><br>Please select "yes" or "no" regarding whether there was a telephone encounter (i.e., the patient called the VA) regarding his/her ARI diagnosis. Please ensure that the telephone encounter occurred ≤30 days after the index visit and addressed the patient's ARI diagnosis.<br><br>If you answer "no" to this question, you are finished with data collection for that patient. If you answer "yes", please proceed to the sub-questions related to item #23. |
| 24a | VA personnel documenting telephone encounter | CPRS -> Notes -> Telephone Encounter Note -> Author<br><br>Determine who documented the telephone encounter as identified as the primary author on the telephone encounter note. The primary author should be found at the top, left-hand side of the note in the heading. Co-signers and additional signers **do not count** as authors for the purposes of the evaluation. |
| 24b | Initiation of the telephone call | CPRS -> Notes -> Telephone Encounter Note<br><br>Please indicate if information available, who initiated the telephone call. For example, did the patient call the VA because his/her symptoms were not improving or did the VA call the patient to check in with him/her? If the information is not specified, please indicate "not documented". |
| 24c | Documentation of patient condition (general) | CPRS -> Notes -> Telephone Encounter Note<br><br>Please indicate if the patient's condition including ARI symptoms was documented during the telephone encounter. |
| 24d | Documentation of patient condition (specifics) | CPRS -> Notes -> Telephone Encounter Note<br><br>Please indicate if the patient's condition was resolving, worsening, unchanged, or not documented. If the patient is having new symptoms without any improvement in prior symptoms, consider the patient's condition to be worsening. Otherwise, use your clinical judgement with the information present or the judgement of the healthcare professional at the time if documented to answer this question. |
| 24e | Clinic visit inquiry | CPRS -> Notes -> Telephone Encounter Note |

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| | | Please indicate whether the patient was asked or a recommendation was made by the healthcare professional that the patient come in for a clinic visit. Note: The patient did **NOT** actually need to come in within any specific time frame for this criterion to be filled. |
| 24f | Medication (symptomatic therapy or antibiotic) initiated | CPRS -> Notes -> Telephone Encounter Note<br><br>Please indicate as documented in the telephone encounter note whether any medication (symptomatic therapy or antibiotic) was recommended or prescribed as a result of the telephone encounter. May also look in pharmacy outpatient medication record; however, please ensure that there is supporting documentation indicating that the prescription is a result of the telephone encounter. |
| 24g | Medication initiation as a result of the telephone encounter | CPRS -> Reports -> Clinical Reports -> Pharmacy -> Outpatient Medications -> Date Range -> Input the dates associated with telephone encounter **AND** CPRS -> Notes -> Telephone Encounter Note -> Treatment Plan<br><br>If an antimicrobial was prescribed, please indicate the following:<br>• Antibiotic Name: Select from the drop down menu. If the antibiotic is not present, select other and fill in the antibiotic that was prescribed<br>• Duration: Determine duration either from the quantity and SIG of the prescription or by documentation in the index visit note<br>• Date filled: Use MM/DD/YY format<br><br>**Note: If more than one antimicrobial was ordered, input each antimicrobial separately.**<br><br>If a medication was prescribed or recommended, select the specific medication, whether it was prescribed or recommended, and the date filled if the medication was prescribed in MM/DD/YY format. If the name of the therapy recommended or prescribed is not in listed in the drop down menu, select "other" and fill in the name. Fill in the name of the generic medication (if specified) and the name of the medication class for each medication prescribed or recommended. If no specific medication is identified, select the class of medication recommended or prescribed.<br><br>Clarifications:<br>• If symptomatic therapy is identified by a brand name, please select the appropriate active ingredient in that product.<br>• If a combination product is identified, select each active ingredient as if each were a separate medication.<br><br>If no antibiotic or symptomatic therapy was prescribed or recommended during this timeframe, move on and do NOT answer this question. Please list each medication separately. You are now finished with data collection. |

**Figure 1: Visual illustration of the worsening criterion for Question #10**

| Day | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
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| X= start of symptoms of an infection<br>XX= symptoms of an infection improves<br>O = worsening symptoms | X | | | | | XX | o | o | o | o |